GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report
Calendar Year 2004

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Mission

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication and unwavering support to child fatality review have made this report possible. These include:

- All the members who serve on each of the county child fatality review committees
- Emily Kahn, Ph.D., MPH, Nicole Alexander, MPH, Maternal and Child Health Epidemiology Section, Epidemiology Branch; Lisa Dawson, MPH and Neha Desai, MPH, Injury Prevention Section, Environmental Health and Injury Prevention Branch, Georgia Division of Public Health
- John T. Carter, Ph.D. Epidemiology Department of Emory University, Rollins School of Public Health
- Georgina Howard, Director of the Office of Vital Statistics
- All the other public/private agencies that have so willingly collaborated with this office and provided support

GEORGIA CHILD FATALITY REVIEW PANEL

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The Georgia Child Fatality Review Panel is an appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

[1]Appointed by the Lieutenant Governor
[2]Appointed by the speaker of the House of Representatives
[3]Ex-Officio

MESSAGE FROM THE CHAIR

Georgia Child Fatality Review Panel

Dear Governor and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, I am pleased to present the 2004 Annual Report. This report is the product of the tireless efforts made by hundreds of volunteers across this state, volunteers in each local child fatality review committee. The work they do in gathering, reviewing and reporting information on child fatalities is invaluable in the fight to protect Georgia's children. The information they provided in 2004 reveals "mixed" results in this battle. For example, the number of deaths resulting from confirmed and suspected abuse and/or neglect increased in 2004, and the number of SIDS deaths was twenty-one percent greater than in 2003. However, there was an appreciable decrease in child deaths attributed to motor vehicle accidents, and deaths from homicides and suicides showed no increase from 2003. A careful reading of the entire report offers some encouragement, but also compels the conclusion that there is still much to be done.

For its part in this struggle, the Panel was very active in 2004, and met with success on several fronts, including the following:

* Achieved a ninety-nine percent compliance rate for county committees reviewing child deaths eligible for review. This is the highest compliance rate in Georgia Child Fatality Review history (95% in 2003, 88% in 2002 and 75% in 2001);

* Increased the number of partnerships to provide training and assistance with local prevention efforts. Partnerships included the Georgia SIDS Project, Georgia Traffic Injury Prevention Institute and Public Health;

* Distributed over 1,000 gun locks to county committees for local distribution;

* Initiated annual recognition of county efforts through the "Coroner of the Year," and "County Committee of the Year" awards;

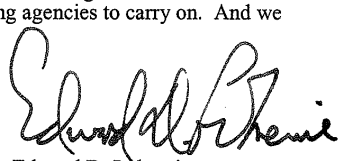
* Created five additional Child Fatality Investigation Teams;

* Realized the appointment of our Executive Director to service on the National Child Death Review Advisory Board;

* Hosted the Southeast Coalition of Child Death Review Program's Annual Meeting;

* Co-sponsored an annual conference with DFCS, Office of Child Advocate and GBI on serious injury and child fatality.

As we review what has been accomplished in the fight to reduce child fatalities in Georgia, and as we make plans for our continued prosecution of this effort, we want to again thank you for your role in all of this. Your leadership, financial backing and counsel enable this Panel, local review committees and numerous participating agencies to carry on. And we will do just that; certainly the prize is well worth the effort.



Edward D. Lukemire,
Chairperson,
Georgia Child Fatality
Review Panel

TABLE OF CONTENTS

List of Figures and Tables

List of Figures and Tables (CONT.)

Preface

Collaboration has become a common "buzz word" among human service professionals. State organizations strongly encourage those at the local level to collaborate, stressing the benefits of working together for the common good of children and families. However, we at the state level have often failed to follow our own advice. Too often we work in silos, and ignore or refuse to address roadblocks that impede quality services to those we assist. The good news is that recent initiatives in the state have been instrumental in fostering collaboration among state organizations.

One such initiative is the First Lady's Children's Cabinet. Mrs. Perdue has successfully convened top-level state executives to consider policies and procedures, as well as gaps in services that yield negative results for children. The outcome of this state collaborative has been positive changes for children. An example is the partnership between DFCS and the State Superintendent of Education's office to ensure prompt school enrollment of foster children. Rules that required paperwork from a previous school district prior to allowing a child enrollment in a new school district were relaxed to prevent interruptions in the education of children.

Another successful effort by the Cabinet was the creation of a summer job program for foster children that included the cooperation of a number of public and private organizations. Young people gained valuable job skills they might otherwise not have had. These efforts are preventive in nature in that they serve to provide meaningful structure and supervision for children and youth, thus deterring involvement in risky behaviors.

Commissioner B. J. Walker has been a catalyst for another collaboration that is proving to be very beneficial for the Office of Child Fatality Review. Public Health, led by Dr. Stuart Brown, has partnered with the Office to provide the expertise of public health staff in aggregating and analyzing data for the Panel's annual report. This year, Public Health has assisted in writing the report, and is responsible for its new layout. We are also currently working on an agreement with Public Health to take the lead in promoting prevention efforts at the local level based on child fatality review data.

Local child fatality review committees have proven the effectiveness of collaboration. We have proudly reported on the increase in child deaths reviewed by committees over the past two years (88% in 2002 and 95% in 2003). The percentage of child fatalities reviewed for 2004 deaths was no exception with 99% of deaths reviewed. This 99% compliance rate is a direct result of professionals on the committees working collaboratively to acquire needed information, and systematically reviewing and reporting those results. Committees are also beginning collaborations to advocate for the implementation of prevention strategies based on data generated from reviews.

Collaboration is key to prevention. Each entity involved in promoting safety and health for children must understand that this work is a continuum of care, and that no one organization can do it alone. When each one brings their strengths to the table, we're much more likely to devise a "map" that will lead us to our desired destination - a place of safety, health, and well being for children.

Executive Summary

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Information in this report details deaths that were sudden, unexplained and/or unexpected. This information is compiled from reports submitted by local child fatality review committees. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

Key Findings

In 2004, 1,760 children died in Georgia. Based on death certificate data, 569 deaths were eligible for review. Child fatality review committees reviewed 564 (99%) of those deaths; however, the cause of death listed on death certificates and the cause of death determined by child fatality review committees sometimes differed due to cause of death coding standards for the death certificate data.

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services reported that 99 children in Georgia died as a result of substantiated abuse or neglect. Those deaths were investigated by DFCS, and did not include deaths handled by law enforcement and the courts without DFCS involvement.

Child fatality review committees determined that 166 child deaths resulted from both confirmed and suspected abuse/neglect (90 confirmed and 76 suspected). The perpetrators and their relationship to the child were identified in 112 of the 166 abuse/neglect related deaths.Sixty-one percent (61%) of those perpetrators were natural parents. Homicide was the cause of 40 confirmed abuse deaths, and children under the age of 5 accounted for 88% (35) of those homicides.

NATURAL

Death certificate data indicated a total of 1,325 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,102) of natural deaths, and leading causes continued to be congenital anomalies, low birth weight, and premature birth. There were 130 SIDS deaths, a 21% increase from the previous year.

Child fatality review committees reviewed 212 deaths from natural causes. One hundred forty-two (142) of those deaths were SIDS/SUID. (SUID – Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that could have contributed to the death.) Committees are required to review all SIDS deaths, and medical deaths that are unexpected or unattended by a physician.

INJURIES

Death certificate data listed 410 deaths to have resulted from known injuries, but 4 of those deaths listed an unknown intent. An additional 25 deaths listed an unknown cause.

Unintentional Injuries

Death certificate data indicated that 61% (354) of deaths in children ages 1 – 17 resulted from injuries (infant deaths [1,178] were mostly due to natural causes [1,102]). Seventy-six percent (76%) of all injuries in the 1 – 17 year age group resulting in death were unintentional (excludes unknown intent and unknown cause). The 3 leading single causes of unintentional injury related deaths in all age groups were:

- 150 motor vehicle incidents
- 39 drowning incidents
- 34 fire/burn incidents

There was a decrease in the number of all deaths caused by unintentional injuries (from 336 to 307) from the previous year. The most marked increase in unintentional deaths from 2003 was fire (25 in 2003 to 34 in 2004).

Child fatality review committees reviewed 322 deaths attributed to unintentional injuries. Child fatality review and death certificate data agreed on the 3 leading causes of death related to unintentional injury, but differed slightly on the number of deaths for each cause as seen below:

- 178 motor vehicle incidents
- 47 drowning incidents
- 40 fire/burn related incidents

Intentional Injuries

Death certificate data indicated 99 children died from injuries intentionally inflicted by themselves or by others. In 2004, there were 75 homicides (a 6% increase from 2003), and 24 suicides (a 4% decrease).

Child fatality review committees reviewed 100 deaths from intentional causes – 74 homicides and 26 suicides. Committees determined additional deaths to have resulted from suicide that were not identified as such on death certificates.

FIREARM DEATHS

Death certificate data indicated firearms were used in 43 child deaths. Thirty-one (31) of those deaths were ruled homicides, 8 were suicides, and the remaining 4 were unintentional.

C**hild fatality review committees** reviewed 44 firearm related deaths. Eighty-two percent (82%) were intentional (27 homicides and 9 suicides). The type of firearm was identified in all 44 of the reviewed firearm related deaths. Handguns were most frequently used (32 of the 44).

UNKNOWN DEATHS

Death certificate data identified 25 infant and child deaths with an "unknown" cause. Child fatality review committees reviewed 23 of those 25 deaths and assigned "unknown" causes to only 7 of the 23 reviewed. They determined the remaining 16 deaths to be drowning (2), medical (4), SIDS (4), and SUID (6).

Child fatality review committees identified 14 deaths for which they were unable to determine a cause of death. Seven (7) of those deaths are referenced above. One reviewed death did not have a DC link. Death certificate causes for the remaining 6 deaths were medical (4) and SIDS (2).

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in all 650 child deaths reviewed. Child fatality review committees determined that 84% (544) of the reviewed child deaths were definitely or possibly preventable. Ninety-six percent (96%) of all reviewed child abuse/neglect related deaths were determined to be definitely or possibly preventable.

AGENCY INVOLVEMENT

Child fatality review committees reported that in 108 (65%) of the 166 child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 10 deaths for which they concluded an agency intervention could have prevented the death. Seven (7) of those 10 deaths had an abuse/neglect finding.

Accomplishments and Recommendations

Accomplishments:

1. Achieved a 99% compliance rate for county committees reviewing 2004 child deaths eligible for review. This is the highest compliance rate in the history of Georgia Child Fatality Review (95% for 2003 deaths, 88% for 2002, and 75% for 2001)
2. Increase in number of partnerships to provide training and assistance with local prevention efforts. Partnerships included the Georgia SIDS Project, Georgia Traffic Injury Prevention Institute, and Public Health
3. Distributed 1000+ gun locks to county committees for local distribution
4. Initiated annual recognition of county efforts through the "Coroner of the Year", and "County Committee of the Year" awards
5. Created five (5) additional Child Fatality Investigation Teams. Because of the highly specialized skills required to thoroughly investigate child deaths, a multi-disciplinary approach was created and has continued to be implemented statewide
6. Executive Director appointed to serve on National Child Death Review Advisory Board
7. Hosted the Southeast Coalition of Child Death Review Programs' Annual Meeting
8. Co-sponsored an annual conference with DFCS, Office of Child Advocate, and GBI on serious injury and child fatality

Legislative Recommendations:

1. Fund expansion of home-based family support models that promote and enable appropriate parenting skills for prevention of child abuse and neglect
2. Require fences and gates around public and private swimming pools statewide
3. Require an autopsy, including toxicology studies, for every death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician. Further, require complete skeletal x-ray (following established pediatric and radiological protocol), of the bodies of children who died before their second birthday
4. Provide sufficient funding to the Georgia Child Fatality Review Panel to fulfill statutory requirements
5. Expand funding for mental health services for children, especially those identified as "at risk"
6. Improve child restraint law to include children under the age of 9, and include pickup trucks in primary restraint law

Agency Recommendations:

1. DFCS: The Panel recommends that when a child dies due to parent(s) or caretaker(s) neglect or aggression, efforts be made to visit the surviving children in the home on an on-going basis for a minimum of 3 months to assess their safety and well-being, and enable referrals to appropriate services
2. Public Health: Implement a statewide campaign that promotes safe infant sleep environments, and explicitly describes dangers posed to infants in bed-sharing and other unsafe sleep environments
3. Coroner and Medical Examiner's Office: The Panel recommends that a death scene investigation be conducted for any child death that is suspicious, unexpected, and/or unexplained

Goals:

1. Continue collaboration with relevant organizations to develop a Statewide Child Injury Prevention Plan
2. Maintain reporting compliance of child fatality review committees at a minimum of 99%
3. Strengthen and standardize procedures employed by state child fatality investigation teams

Georgia Child Fatality Investigation Program

The investigation of the death of a child is unique because of the nature of medical findings from the autopsy in the vast majority of cases. Recognizing that such investigations are quite different from adult homicide investigations, experts involved in these cases around the country have begun to utilize a multi-disciplinary team approach from the inception of such investigations. Unlike the approach to adult homicides, in which each discipline becomes involved separately in time and allocation of effort, this team approach maximizes the information-gathering and decision-making capabilities of authorities. Child death investigation teams recognize the value of employing the unique expertise and resources each involved agency brings to the investigation. These teams utilize highly trained representatives from their own district attorney's offices, local law enforcement agencies, coroners and/or medical examiners, and the Department of Family and Children Services. These teams immediately respond and share information from the inception of the case, thereby encouraging better investigations with more obtainable evidence. Regional specialists from the Georgia Bureau of Investigation are available to assist teams as well. This is an investigative trend that Georgia has begun to embrace statewide.

The Georgia Child Fatality Investigation Program was created to develop and support these multi-disciplinary child death investigation teams in communities around the state. The program is administered by the Georgia Child Fatality Review Panel, through collaboration with the Georgia Bureau of Investigation and the Department of Family and Children Services.

Numerous jurisdictions around Georgia have agreed to participate in the Georgia Child Fatality Investigation Program and have received assistance and training upon request and without any cost. The program is available for consultation and review of both new and old cases and many jurisdictions have availed themselves of the opportunity to put a "fresh eye" on cases by referring them to the program. Model protocols are available as well as initial and follow-up trainings and case consultations. Resource notebooks designed for teams to utilize at death scenes are offered to participating teams as well.

The original jurisdictions involved in the pilot program include: Lookout Mountain Judicial Circuit, Middle Judicial Circuit, Douglas Judicial Circuit, Dougherty Judicial Circuit, Stone Mountain Judicial Circuit, Eastern Judicial Circuit, Rome Judicial Circuit, Northeastern Judicial Circuit, Alcovy Judicial Circuit, Southern Judicial Circuit, and Tifton Judicial Circuit. Blue Ridge Judicial Circuit, Bell-Forsyth Judicial Circuit, Clarke Judicial Circuit, Rockdale Judicial Circuit, and Gwinnett Judicial Circuit enrolled in the program in 2004. In 2005, the Flint, Cobb, Clayton and Macon Circuits joined the program, and the Douglas Circuit re-established their team.

The program's focus in 2006 will be working with teams to standardize reporting tools to ensure more uniformity of data collected across the state.

In 2004, 569 cases of child death were considered eligible for review by Child Fatality Review teams. The goal of the Program is to ensure that proper scene investigation is performed in all appropriate cases, and that involved agencies work in concert with one another from the inception of the investigation.

Information Sources and Inconsistencies

This annual report on Georgia's 2004 infant and child fatalities uses two related but independent sources of data – death certificate (DC) data collected by the Vital Statistics Unit and prepared by the Office of Health Information and Policy (OHIP), and the child fatality review data collected by the Office of Child Fatality Review. These two data sources do not always agree on the cause or manner of death. Child fatality review reports are the primary source of data for this report.

Death certificate data is used to identify the set of "reviewable" infant and child deaths. The cause of death is reported on the DC by ICD10 codes (International Classification of Diseases). ICD10 codes corresponding to deaths due to unknown or undetermined cause, SIDS, and any death due to injury or violence are used to define "reviewable" deaths. A medical examiner, coroner, or CFR team may also determine that a death should be reviewed because of the circumstances of the death (e.g., the child was not under the care of a physician). Thus, the total number of reviewed deaths in a county may exceed the number of deaths identified as "reviewable" based on the death certificate.

Child fatality review reports provide details of the cause, manner and circumstance of death, supervision at time of death, prior history of abuse or neglect, others identified as causing or contributing to child deaths, and prior agency involvement. Reports also contain information regarding whether a death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

Though death certificate and child fatality review data do not always agree, the causes of death are consistent between the two sources for a majority of deaths. The team may have had access to additional information, leading to a different conclusion regarding the cause and/or manner of death. The system used in the coding of the causes of death on the death certificate, the ordering of reported codes to select the underlying cause, and the collapse of codes into categories all contribute to error in the classification of the death certificate "cause" of death. One of the values of the CFR process is that it provides a check on the death certificate coding of cause.

The process of linking the death certificates and child fatality review reports is not perfect. In 2004, there were 14 child fatality review reports with no identified matching death certificate. (Those deaths would only be included in the "Total Reviews" data in Appendix E.) There were 80 reviews that reported a different cause of death than was determined from the ICD-10 coding for cause of death on the death certificate. Though some adjustments have been made to the cause of death or county of residence in the death certificate data based on information gathered in reviews, there are additional identified differences that have not been reconciled. In some cases there was apparent miscoding of the cause of death on the death certificate, and those deaths have been identified to Vital Statistics. However, as previously stated, the "reviewable deaths" have been defined based on the

Child Deaths in Georgia

In 2004, the State of Georgia experienced the loss of 1,760 children due to medical, intentional and unintentional injury-related deaths. Existing research shows that a majority of injury-related deaths are preventable. This is evident in the Georgia Child Fatality Review (CFR) findings. County child fatality review committees formally reviewed a total of 564 (or 99%) of child death cases eligible for review in 2004.

The top three overall causes of death for individuals less than 18 years of age were medical, motor vehicle-related incidents and Sudden Infant Death Syndrome (SIDS). Aside from medical deaths, motor vehicle-related incidents continued to be the leading cause of death in children less than 18 years of age, while Sudden Infant Death Syndrome (SIDS) was the leading cause of death in infants. Cause of death is further subdivided by factors such as gender, age and race to show greater detail and highlight areas for possible intervention. The sections that follow illustrate cause and topic-specific data, findings, and recommendations resulting from 2004 CFR reports.

Figure 1: Deaths to Children Under Age 18 in Georgia All Causes Based on Death Certificate, 2004 (N=1760)

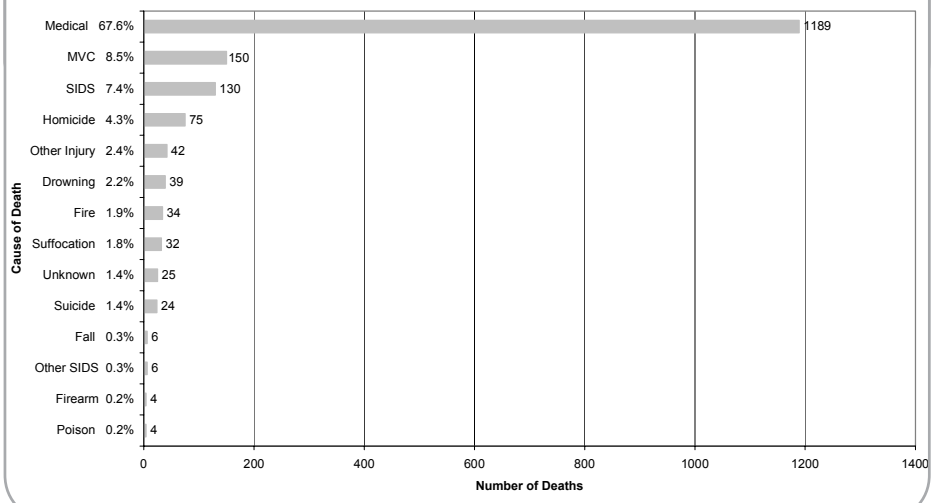
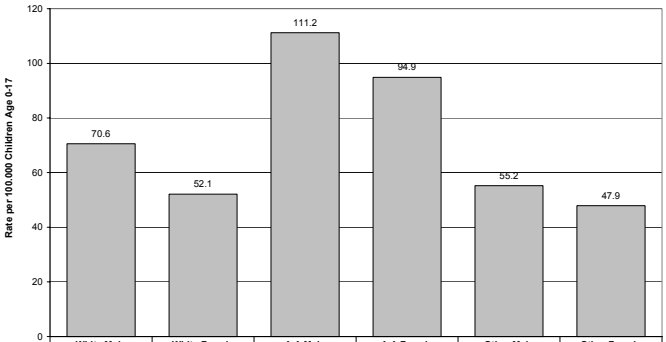


Figure 1 shows the cause of death, based on death certificate information, for every child death in 2004.

Findings:

- The number of child deaths has decreased slightly from the previous several years from an average of 1,796 between 2001 and 2003 to 1,760 in 2004
- Although two thirds of all child deaths were due to medical causes, infants accounted for 81% of those deaths. Examples include deaths due to complications of prematurity and low birthweight, and diseases such as leukemia. (SIDS is not included in medical deaths.)
- The second leading cause of death overall was motor vehicle-related incidents
- SIDS, the third leading cause of death increased from 103 to 130 deaths

Figure 2: All Child Death Rates per 100,000 Children Age 0-17 by Race/Gender Categories, 2004 (N=1760)



	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female
Rate	70.6	52.1	111.2	94.9	55.2	47.9
# of Deaths	515	358	454	378	30	25

Figure 2 shows the rate and number of child deaths by race and gender. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons. For example, the largest number of deaths was to White males; however they also make up the largest population group. Thus, they do not have the highest rate of death.

Findings:

- Child deaths disproportionately occur among African-Americans. The rate for African-American males is 1.6 times higher than for White males. The rate for African-American females is 1.8 times higher than for White females
- Males are more likely to die than are females. Within each racial category, the rate for males is higher than that for females

Figure 3: Leading Cause of Death by Age Group, Georgia, 2004 (N=1760)

	Age Group in Years					
Rank	**<1 1178 (67.0%)**	**1-4 189 (10.7%)**	**5-9 94 (5.3%)**	**10-14 129 (7.3%)**	**15-17 170 (9.7%)**	**All Deaths <18 1760 (100%)**
1	Medical 966 (82.0%)	Medical 85 (45.0%)	Medical 35 (37.2%)	Medical 60 (46.5%)	MVC 62 (36.5%)	Medical 1189 (67.6%)
2	SIDS 130 (11.0%)	MVC 28 (14.8%)	MVC 18 (19.2%)	MVC 34 (26.4%)	Medical 43 (25.3%)	MVC 150 (8.5%)
3	Suffocation 22 (1.9%)	Homicide 23 (12.2%)	Homicide 11 (11.7%)	Suicide 9 (7.0%)	Homicide 20 (11.8%)	SIDS 130 (7.4%)
4	Unknown 20 (1.7%)	Fire 18 (9.5%)	Fire 10 (10.6%)	Fire 6 (4.7%)	Suicide 15 (8.8%) Other Injury 15 (8.8%)	Homicide 75 (4.3%)
5	Homicide 18 (1.5%)	Drowning 15 (7.9%)	Drowning 8 (8.5%) Other Injury 8 (8.5%)	Drowning 5 (3.9%)	Drowning 9 (5.3%)	Other Injury 42 (2.4%)

Figure 3 shows the five most common causes of death for each age group, as well as the percent of all child deaths occurring within each age group.

Infants
- 67% of all child deaths were to infants (children less than one year old)
- 82% of infant deaths were due to medical causes, primarily complications of prematurity and low birthweight and birth defects. The second leading cause, accounting for another 11% of infant deaths, was SIDS

Ages 1-4 (Early Childhood)
- 11% of all child deaths occurred to children between the ages of 1 and 4 years
- The largest group of deaths were due to medical causes, including: birth defects, respiratory diseases, cardiovascular diseases and cancer

Ages 5-9 (Middle Childhood)
- The fewest child deaths (5%) occurred in this age group
- Motor vehicle-related incidents were the most common cause of non-medical deaths

Ages 10-14 (Early Adolescence)
- 7% of child deaths occurred among children between the ages of 10 and 14
- Motor vehicle-related incidents were the second leading cause of death; however in this age group, they account for a larger percentage of deaths than in younger ages. Twenty-six percent of child deaths in this age group were caused by motor vehicle-related incidents, compared with 19% for 5-9 year olds and 15% for 1-4 year olds

Ages 15-17 (Later Adolescence)
- 10% of child deaths occur among teens between the ages of 15 and 17
- In this age group, motor vehicle-related incidents surpass medical causes of death to become the leading cause of death overall. Motor vehicle-related incidents accounted for 37% of deaths to teens between the ages of 15 and 17

All 2004 Reviewed Deaths

In 2004, 569 of the total 1,760 child deaths met the eligibility criteria requiring review (injuries and SIDS) according to death certificate data. A child's death is eligible for review when the death is unexpected or unexplained (resulting from intentional/inflicted injuries, unintentional/accidental injuries, Sudden Infant Death Syndrome, medical causes unattended by a physician, or suspicious or unusual circumstances). Committees filed reports for 99% (564) of those deaths within the reporting period, representing an increase of 3% since 2003. Committees reviewed an additional 86 child deaths of which 70 were attributed to medical causes. (Medical deaths are indicated for review only if unexpected or unattended by a physician.) A total of 650 deaths were reviewed. Complete data on reviewed child deaths are available in Appendix C.2.

Why review child deaths?
The purpose of the child fatality review process is to analyze all circumstances of child deaths. This review process also considers any critical factors which contributed to a child's death and could have been prevented. This is critical in identifying strategies that can help reduce preventable injuries and deaths for Georgia's children.

Setting aside medical deaths, the top three causes of all reviewed infant and child deaths in Georgia in 2004 were motor vehicle-related incidents (27%), Sudden Unexpected Infant Death (14%) and homicide (11%).

The distribution of child deaths in Georgia is generally proportional to the county population.
- The 13 counties with 10 or more reviewable deaths in 2004 have 49% of the child population and 47% (266) of all reviewable deaths. Those counties reviewed 97% (259) of their 266 reviewable deaths
- The 98 counties with 1 to 9 reviewable deaths reviewed 305 of their 311 reviewable deaths (98%) Only one county (Peach) did not review any of their deaths, and that county had only 1 reviewable death
- Eight (8) counties had no child fatalities in 2004, and an additional 33 counties had no child deaths that met the criteria for review

Information and figures for the following sections include eligible child deaths reviewed by committees. Medical deaths, and deaths with unknown data, are not included unless otherwise noted.

Figure 4: Causes of Death, All Reviewed Infant/Child Deaths, Georgia, 2004 (N=650)

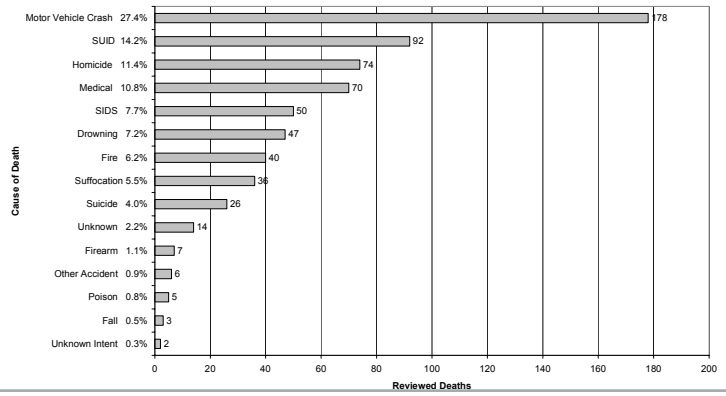


Figure 4 shows the cause of death for all 650 deaths reviewed by the Child Fatality Review committees in 2004. In some cases, the numbers for causes of death differ from those given by death certificates since the review process often uncovers additional information that was not available at the time that the death certificate was filed.

Findings:

- Motor vehicle-related incidents remained the leading cause of reviewed deaths for children (27%)
- Sudden Unexplained Infant Death (SUID) was again the second leading cause of reviewed deaths (14%), consistent with data from 2003
- The number of reviewed deaths associated with SIDS decreased in 2004. This increase may be due to the increased use of "SUID" (Sudden and Unexplained Infant Death) by the committees where there were other factors identified which could have contributed to the death
- The SIDS/SUID categories together increased from 2003. Committees reviewed a total of 142 infant deaths attributable to either SIDS or SUID
- Homicide was again the third leading cause of reviewed deaths for children (11%), consistent with data from 2003

Preventability

When CFR committees investigate a child death, there are factors which identify the degree to which the death could have been prevented. Analyzing those factors surrounding the death enable us to learn ways in which we can exert influence to prevent future child fatalities. Specifically examining factors *prior* to an injury event, *during* an injury event, and *immediately after* an injury event helps to clarify the circumstances that contributed to death.

Table 1: Preventability, All Reviewed Infant/Child Deaths, Georgia, 2004 (N=650)

		%
Definitely Preventable	276	42.5%
Possibly Preventable	268	41.2%
Not Preventable	106	16.3%

What is a preventable death?

While a CFR committee's designation of the preventability of a child's death is subjective, generally, if a death is identified from *retrospective analysis as foreseeable*, or resulting from the absence of *reasonable intervention* (e.g., medical, educational, social, psychological, legal, or technological), then the death is deemed "preventable". All intentional (inflicted) and most unintentional (accidental) injury deaths are preventable. It is critical that committees advocate for the implementation of recommendations made to prevent child deaths.

Findings:

- CFR committees found that 84% of reviewed deaths were either possibly or definitely preventable
- 96% of deaths related to abuse/neglect were determined to be possibly or definitely preventable

Child Abuse and Neglect

In the last decade of the millennium, the number of children reported as abused or neglected in the United States grew by 33% - to 3.2 million a year. The actual incidence of abuse and neglect is estimated to be three times greater than the number reported to authorities. Nine in ten Americans polled regard child abuse as a serious problem, yet only 1 in 3 reported abuses when confronted with an actual situation (Child Help USA).

What is included in the definition of "abuse and/or neglect"?
Abuse is any act, or a failure to act, on the part of a parent or caretaker, that results in serious physical or emotional harm, sexual harm or exploitation, or death of the child. Neglect is the failure to provide for the child's basic physical, emotional, educational, or medical needs. Negligent treatment is often fatal when due to withholding nutrition or necessary health care, or grossly inadequate physical protection. Neglect is also a failure to protect the child from harm or potentially hazardous situations.

How does Georgia compare with the U.S. average?
In 2003, an estimated 1,500 children died from abuse or neglect in the United States (a rate of 2 per 100,000), with 161 of those children from Georgia (a rate of 2.1 per 100,000). (US Department of Health and Human Services, Administration for Children and Families, 2003). Nationally, approximately 80% of perpetrators are parents, with women representing a larger percentage than men. In Georgia, 87% of child abuse occurs in the child's home, and 83% of those who abuse children are the child's biological parents. (Prevent Child Abuse Georgia)

Child fatality review committees determined 166 reviewed child deaths (26%) had evidence for suspected (76) or confirmed (90) child abuse and/ or neglect. (Data on the cause of death, age, race, and gender for those deaths are included in Appendix C.3 of this report.)

Domestic Violence and Child Abuse
According to the Child Welfare League of America, between 3.3 million and 10 million children witness some form of violence in the home each year nationwide. Domestic violence often includes child abuse. Nationally, it is estimated that 53-70% of individuals who batter their partners also abuse their children. Children may be victimized and threatened as a way of punishing and controlling the adult victim of domestic violence, or they may be injured unintentionally when acts of violence occur in their presence. It has been suggested that domestic violence may be the *single major precursor* to child abuse and neglect fatalities in this country (Family Violence Prevention Fund, 2005).

A history of domestic violence in the home of the caretaker was also associated with a committee finding of child abuse. For those decedents with abuse/neglect findings (suspected or confirmed), 29% (23) had a history of domestic violence in the home of the caretaker, when information was available.

Figure 5: Causes of Death Among Reviewed Deaths with Abuse/ Neglect Findings, Georgia, 2004 (N=166)

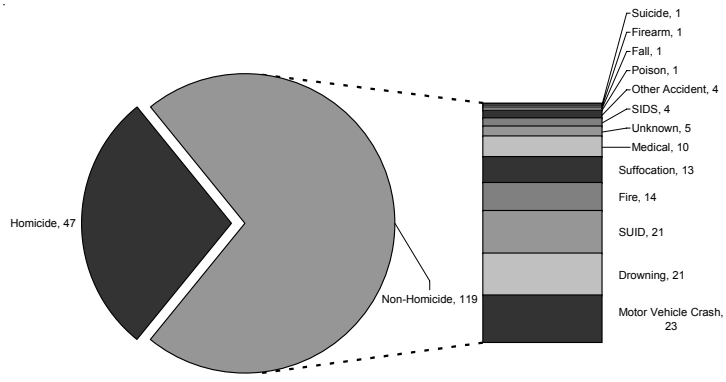


Figure 5 shows the causes of death for those deaths in which child abuse and/or neglect was suspected or confirmed.

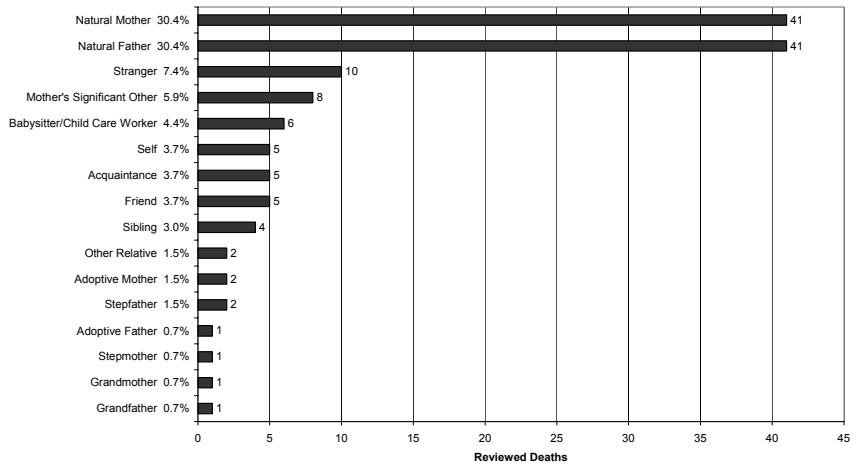
Findings:

- 28% of the 166 reviewed deaths with child abuse or neglect findings were homicides
- Total number of deaths with abuse or neglect findings increased slightly from 161 in 2003 to 166 in 2004

Fact:

- Research studies of infant death data drawn from multiple agency records (e.g., police or social service records) indicate that the actual rate of infant deaths attributable to substantial abuse or neglect of infants and children up to four years of age is more than twice as high as the official rates reported on death certificate data

Figure 6: Relationship of Perpetrator to Decedent in Reviewed Cases with Abuse/Neglect Findings, 2004 (N=166)



*Some child abuse/neglect-related deaths involved more than 1 perpetrator

Figure 6 shows the relationship of the perpetrator to the child where the death involved suspected or confirmed child abuse or neglect.

Findings:

- 82 parents were identified as perpetrators in deaths with suspected or confirmed child abuse/neglect. Mothers and fathers were equally likely to be the perpetrator
- The mother's significant other was involved in 8 deaths with child abuse/neglect findings
- A babysitter or child care worker was involved in the deaths of 6 child abuse/neglect-related deaths

Fact:

- Infants are most likely to be killed by their mother during the first week of life but are more likely to be killed by a male (usually their father or stepfather) thereafter

"Ten-month-old died after being strangled by her father with a cord from a hair dryer. The father had a history of violence and abuse towards the mother and children."

Figure 7: Reviewed Deaths with Abuse/Neglect Findings By Age, 2004 (N=166)

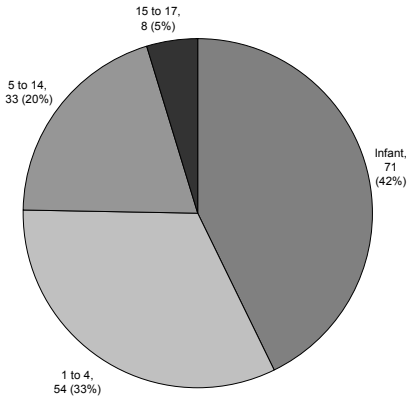


Figure 7 shows the percent of child abuse/neglect deaths for categories of children's age. The proportion of child abuse/neglect-related deaths decreases as the child gets older.

Findings:

- 75% of all abuse/neglect deaths occurred among pre-school-aged children. This is an increase from 2003 (70% were under the age of 5)
- The number of cases of abuse or neglect increased 15% for <1 year olds (from 62 infants in 2003 to 71 in 2004)
- Infants were five times more likely to have an abuse/neglect related death compared to children age 1 to 4, and 25 times more likely to have an abuse/neglect related death compared to children ages 15 to 17

Fact:

- Infants and young children experience more abuse/neglect related deaths because of their overall vulnerability and development stage, their dependency on caretakers for all personal needs, and their limited contact with mandated reporters

Figure 8: Reviewed Deaths with Abuse/Neglect Findings by Race and Gender and Rate per 100,000 Children Age 0-17, 2004 (N=166)

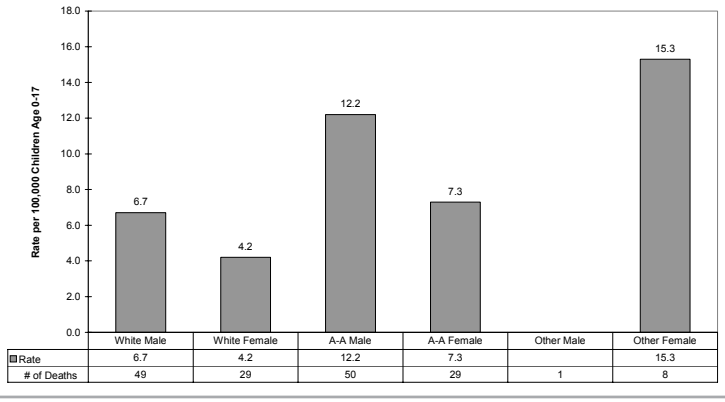


Figure 8 shows the rate and number of deaths with abuse and neglect findings by race and gender. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons. While the number of abuse and neglect related deaths are equal for African-Americans and Whites, the African-American population is smaller, leading to higher rates of abuse/neglect related deaths for African-Americans.

Findings:

- Overall, African-Americans were 1.8 times more likely to die with abuse/neglect findings than Whites
- African-American males had the highest rate of deaths related to abuse or neglect
- As in 2003, African-American males are almost twice as likely to experience abuse/neglect related deaths compared to White males, and three times more likely compared to White females

Opportunities for Prevention:

For parents

- Be aware of children who may display signs and symptoms of maltreatment. Be prepared to report abuse or neglect
- Participate in classes that teach developmental stages of children, and age-appropriate disciplinary practices

For community leaders and policy makers

- Expand training for legally mandated professionals on recognition and reporting of child abuse and neglect
- Support development and training of first responders to cases of child abuse and neglect
- Support and facilitate public education programs that target caretakers and child care providers

For professionals

- Support crisis teams and victim advocacy for children who witness violence
- Encourage community-based violence prevention programs
- Learn how to recognize and report child abuse and neglect

Resources:

National Coalition Against Domestic Violence: 1-800-799-SAFE (7233) or www.ncadv.org
Prevent Child Abuse Georgia: 1-800-CHILDREN (1-800-244-5373) or www.preventchildabusega.org

Prior Agency Involvement

Fifty-three percent (344) of the 650 child fatality review reports received for 2004 indicated that *one or more community agencies had prior interaction with the deceased child or his/her family*. Agencies were not necessarily actively involved with the number of deaths in which they were identified. A child or family was often involved with more than 1 agency; therefore, the number of involvements children/ families had with agencies exceeded the number of deaths.

Figure 9: Agency Involvement Among Reviewed Deaths by Abuse/ Neglect Status, 2004

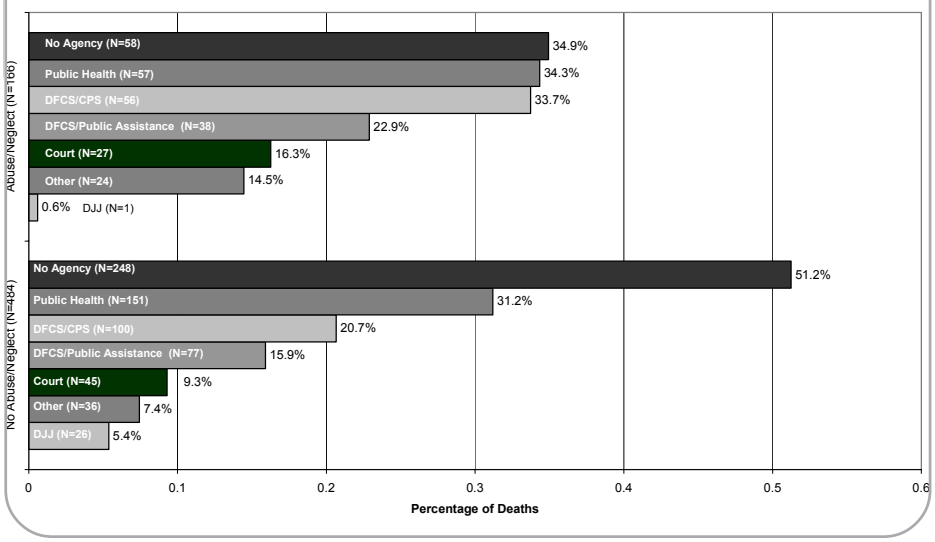


Figure 9 shows prior agency involvement for children who have died. Involvement with governmental agencies before death provides opportunities for earlier recognition of risk and for intervention with the caretaker.

Findings for Children with No Abuse or Neglect History:

- 51% of deaths with no abuse findings had no prior agency involvement
- Families had involvement with an average of 0.8 agencies
- 21% of children and/or their families had involvement with Child Protective Services (CPS)
- 31% of children and/or their families had involvement with Public Health

Findings for Children with Abuse or Neglect History:

- 65% of children with abuse/neglect related death had prior agency involvement
- Families had involvement with an average of 1.1 agencies
- 34% of children had involvement with Child Protective Services (CPS)
- 34% of families had involvement with Public Health

Fact:

- Professionals who work with governmental and other public agencies are mandated to report suspected abuse or neglect, yet often receive little or no formal training in identification of risk factors or signs of abuse

Table 2: Reported CPS Involvement Among Deaths with Abuse/ Neglect Findings, 2004 (N=56)

Decedent	14
Decedent and Other Child in Family	7
Other Child in Family, Not Decedent	16
Decedent, Other Child in Family and Caretaker	10
Caretaker	2
Other Child in Family and Caretaker	1
Decedent and Caretaker	3
Not indicated on CFR Report	3

Table 2 depicts reported involvement with Child Protective Services (CPS) among deaths with abuse/neglect findings (N=56).

Opportunities for Prevention:

For community leaders and policy makers

- Enforce mandated reporting
- Expand training for legally mandated professionals on recognition and reporting of child abuse and neglect
- Support development and training of community agency staff to identify, recognize and appropriately respond to suspicions of child abuse or neglect

For professionals

- Participate in trainings to learn how to recognize and report child abuse and neglect
- Be aware of abuse and neglect prevention research literature and legislation

Sleep-Related Infant Deaths

Sleep-related deaths are the leading cause of non-medically related deaths for children birth to 1 year of age. Prone (lying on stomach) sleep and unsafe sleep surfaces increase the risk of sleep-related infant deaths. Recent studies also suggest that when an infant's head or face is covered by bedding (i.e. pillow, sheet, or blanket), or when the infant's sleep surface is shared with other people, the risk of death increases.

What is included in the definition of sleep-related deaths?
Sleep-related deaths include all deaths to infants that occur while sleeping, but have no medical cause. Included are Sudden Infant Death Syndrome (SIDS), Sudden Unexplained Infant Death (SUID) and all suffocation/asphyxia deaths related to a sleep environment. SIDS is the sudden unexpected death of an apparently healthy infant under 1 year of age which remains unexplained after performance of a complete post-mortem investigation that includes an autopsy, investigation of the death scene, and review of case history. SUID is a death that appears to be SIDS but has other factors present that could have contributed to the death. Asphyxia occurs when there is an extreme decrease of oxygen in the body, accompanied by an increase in carbon dioxide, and usually caused by an interruption of breathing or suffocation. Risk factors to all sleep-related deaths include over heating, tobacco use during and after pregnancy, a prone sleeping position, and unsafe sleeping arrangements (i.e., a sleep surface not designed for an infant, excessive bedding, toys or decorative bumper guards, sleeping with head or face covered, or sharing a sleep surface with multiple persons or a person that is excessively tired or intoxicated).

How does GA compare with the U.S. average?
According to the National Institute on Health, since the "Back to Sleep" campaign began 10 years ago, the SIDS rate for African-Americans has declined dramatically, as it has for the total population. Still, the SIDS rate for African- Americans is twice that of Whites. The Georgia rate for African-Americans is similar to the national rate. Despite the dramatic decline in SIDS over the last decade, SIDS still claims the lives of roughly 2,500 infants each year in the U.S.

In Georgia, 142 infants died in 2004 of SIDS or SUID and an additional 25 children died of sleep related asphyxia. African-American females showed the highest incidence of disproportionate deaths for all sleep related categories.

Asphyxia

Figure 10: Reviewed Sleep-Related Asphyxia Deaths, Age <1, By Month, 2004 (N=25)

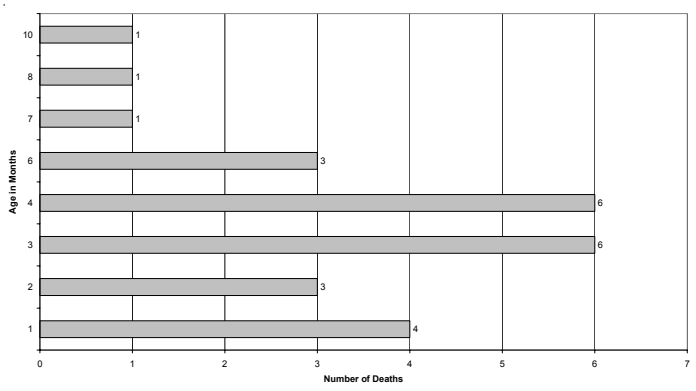


Figure 10 shows the age in months at death for the 25 children with sleep-related asphyxia deaths.

Findings:
- 19 (76%) infants were younger than six months when they died
- The most common ages at death were 3 months and 4 months

Fact:
- The hazard of asphyxia-related death has been reported to be greater in infants less than 5 months of age but may occur in children up to the age of 2 years

"Child was sleeping in a bed with his father and 5-year-old sibling. He was found wedged between the mattress and the headboard"

Figure 11: Number of People Sleeping with Infant at Time of Death, 2004 (n=25)

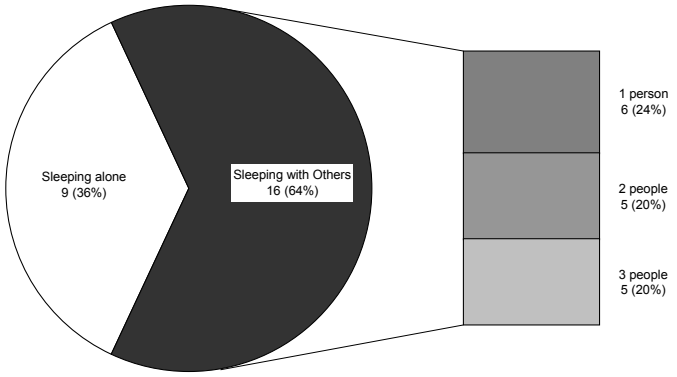


Figure11 shows whether the infant was sleeping alone or sleeping with others at the time of death.

Findings:

- 9 infants (36%) were sleeping alone when they were discovered
- 16 infants (64%) were sleeping with others at the time of death. Of these 16, 6 were sleeping with one other person and 10 were sleeping with more than one other person

Fact:

- Studies show that infants sleeping in the same bed as their parents are at an increased risk of death, predominantly by overlaying

SIDS and SUID

Figure 12: Reviewed SIDS/SUID Deaths By Age, 2004 (N=142)

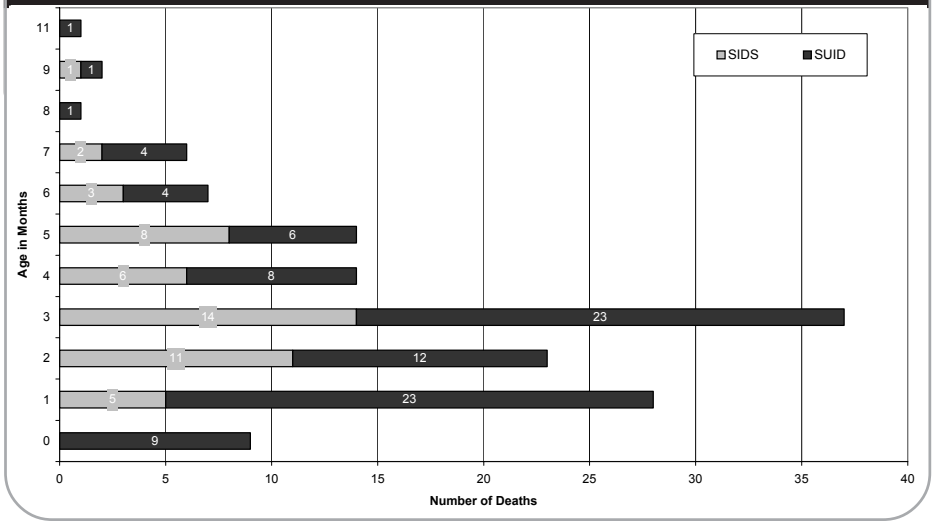
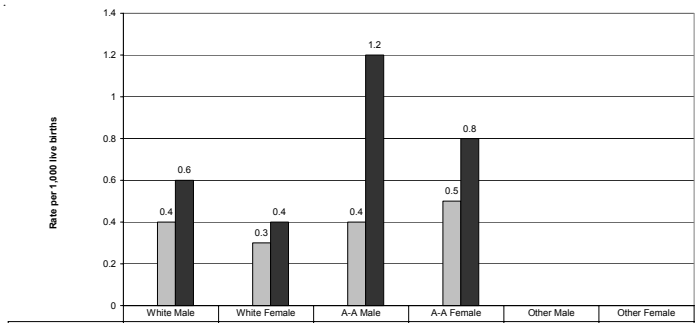


Figure 12 shows the age in months of all children who died of Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Death (SUID).

Findings:

- The most common age for both SIDS and SUID deaths was three months
- 68% of all SIDS and SUID deaths occur in children younger than four months

Figure 13: Reviewed SIDS/SUID Deaths By Race, Gender and Rate per 1,000 live births, 2004 (N=142)



	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female
# SIDS Deaths (N=50)	17	11	10	10	2	0
SIDS Death Rate	0.4	0.3	0.4	0.5		
# SUID Deaths (N=94)	29	17	26	17	2	1
SUID Death Rate	0.6	0.4	1.2	0.8		

Figure 13 shows the rates and number of SIDS and SUID deaths by race and gender. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

Findings:

SIDS

- SIDS rates are similar for African-American males, White males and African-American females with rates between 0.4 and 0.5 deaths for every 1,000 infants born
- White females have a lower SIDS rate, with 0.3 deaths for every 1,000 infants born

SUID

- African-American infants are 2 times more likely to die of SUID than White infants
- Males were 1.5 times more likely than females to die of SUID

Figure 14a: Sleeping Position of Infants who Died of SIDS, 2004 (N=50)

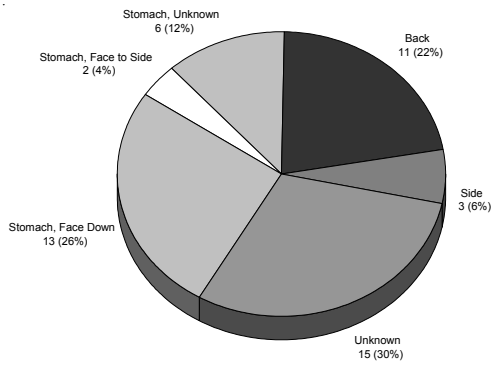


Figure 14b: Sleeping Position of Infants who Died of SUID, 2004 (N=92)

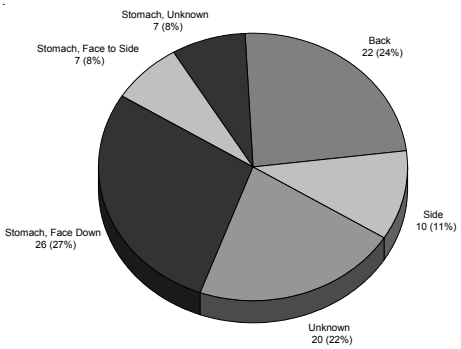


Figure 14a shows the sleeping position for the 50 infants who died of SIDS. Figure 14b shows the sleeping position for the 92 infants whose deaths were classified as SUID.

Finding:

- When known, sleeping position for SUID deaths was similar to SIDS deaths. Better information on the unknowns could significantly alter these results

Figure 15a: Location at Time of Death for Infants who Died of SIDS, 2004 (N=50)

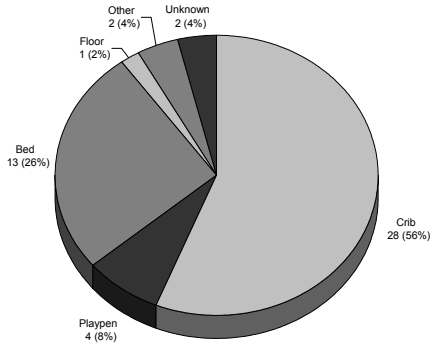


Figure 15b: Location at Time of Death for Infants who Died of SUID, 2004 (N=92)

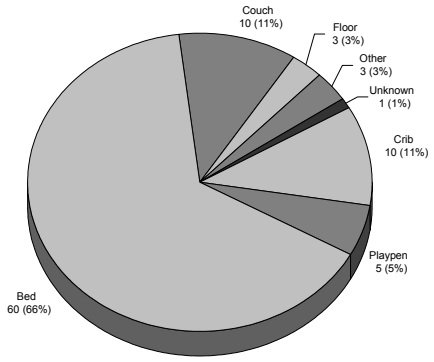


Figure 15a shows the sleeping location for the 50 infants who died of SIDS. Figure 15b shows the sleeping location for the 92 infants whose deaths were classified as SUID.

Findings:

- 56% of infants with SIDS deaths were found in a crib. Only 11% of infants with SUID deaths were found in a crib
- The most common location for SUID deaths was a bed (65%), while beds were the sleeping location for 26% of SIDS deaths
- An additional 11% of infants with SUID deaths were found on couches

Figure 16: Items in Contact with Infants who Died of SUID, 2004 (N=92)

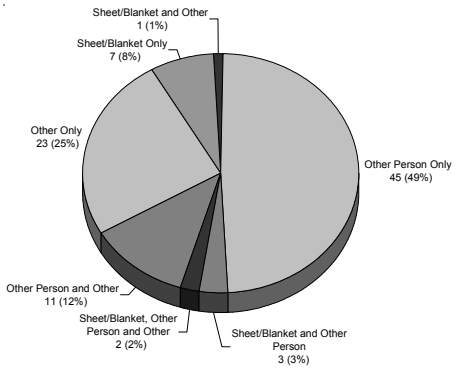


Figure 16 shows the items that were found in contact at time of death with infants whose deaths were classified as SUID.

Finding:

- 66% of SUID infants were indicated to be bed-sharing (sharing a sleep surface)

Fact:

- Infants who share a bed with other children are at increased risk for SIDS/SUID (Georgia SIDS Alliance)

"This 6-week-old infant shared a bed with his 6-year-old sister and 24-year-old mother. He was found unresponsive, prone, on multiple blankets in a king-sized bed. Autopsy findings show bed sharing as a possible complicating factor."

Figure 17. SIDS Death Rates per 1,000: Age<1 (Based on Death Certificates), Three Year Moving Average, 1994-2004

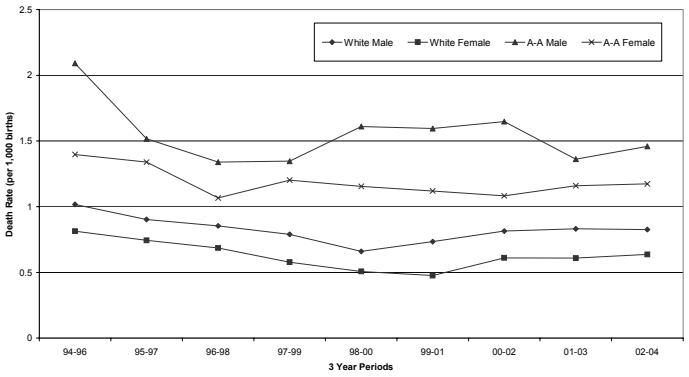


Figure 17 shows 10-year trends in SIDS rates by race and gender. Since SIDS information in this figure comes from death certificates, SIDS and SUID are combined.

Findings:

- SIDS rates have consistently been highest for African-American infants; both African-American males and females have higher rates than their White counterparts
- Males have higher SIDS rates than do females
- SIDS rates have declined since 1994, particularly among African-American males, however there has been a slight increase since the late 1990s, for all race/gender groups

Facts:

- Since the American Academy of Pediatrics (AAP) launched the "Back to Sleep" campaign over a decade ago (promoting that infants be placed to sleep on their backs), the overall rate of SIDS deaths has declined by 50%
- While the cause of SIDS is unknown, factors such as soft sleep surfaces and sleep position continue to be associated with SIDS

Opportunities for Prevention:

For parents:

- Infants should be placed on their backs to sleep throughout the first year of life
- Consider co-sleeping (sleeping in the same room with the infant), instead of bed-sharing (sleeping in the same bed)
- Place infants on a firm, tight-fitting mattress in a crib that meets current safety standards
- Remove stuffed animals, toys, bumper pads, and soft bedding (e.g. quilts, comforters, sheepskins) from cribs
- Avoid placing infants to sleep on soft surfaces (e.g. comforters, sofas, pillows, waterbeds) or sleep surfaces shared by others
- Consider using a sleeper or other sleep clothing as an alternative to using a sheet/blanket in a crib and to avoid overheating
- Avoid smoking during pregnancy
- Create a smoke-free environment around the baby after birth

For community leaders and policy makers:

- Support Safe-Sleep campaigns
- Increase prevention efforts focused towards the African-American community

For professionals:

- Newborn nursery personnel, physicians, nurses and public health officials should instruct all new parents and child care personnel in safe sleeping practices and other strategies to reduce the risk of SIDS

Unintentional Injury-Related Deaths

Unintentional injuries are a leading cause of death for Americans of all ages, regardless of gender, race, or economic status. They are the leading killer of children ages 1-17. Each year in the United States approximately 7,200 children ages 14 and under are killed and another 50,000 are permanently disabled. More children ages 1-17 die from unintentional injuries than from all childhood diseases combined (Safe Kids Worldwide, 2005).

What is an unintentional injury-related death?
An unintentional injury death is one that results from carelessness or negligence. It is an unexpected and undesirable event. This category includes those injuries and poisonings described as unintended regardless of whether the injury was inflicted by oneself or by another person. It does not include deaths whose intent was unknown.

How does GA compare with the U.S. average?
The crude rate for unintentional injury related deaths among children in Georgia was 1.2 times higher than the U.S. (12.0 per 100,000) at 14.6 per 100,000.

Figure 18: Reviewed Unintentional Injury-Related Deaths by Cause, 2004 (N=322)

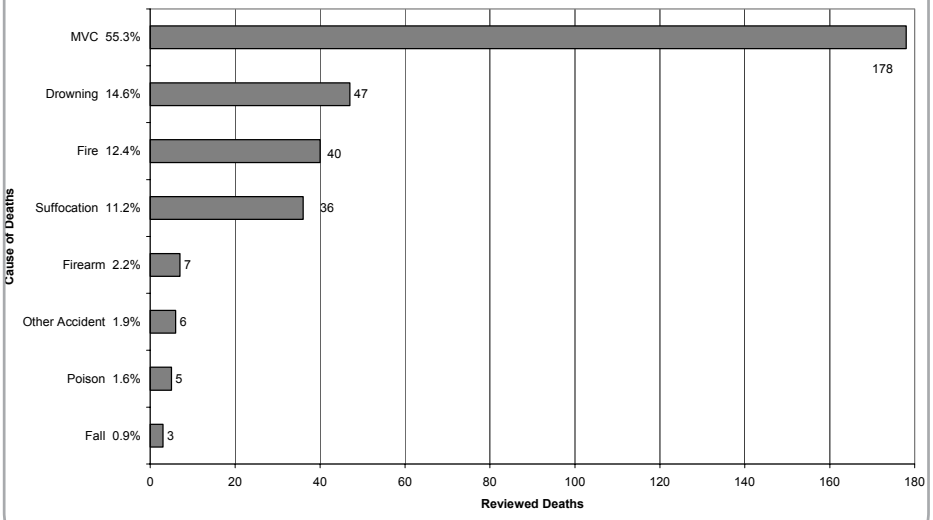


Figure 18 shows causes of death for the 322 children who died from unintentional injuries.

Findings:

- Motor vehicle-related deaths accounted for the majority (55%) of unintentional injury deaths. Total number of motor vehicle-related incidents decreased from 206 in 2003
- Fire deaths showed the biggest increase (from 24 in 2003 to 40 in 2004)
- Drowning accounted for the second largest percent (15%) of unintentional injury deaths

Fact:

- Among children age 1-14 all unintentional injuries combined outnumber medical deaths for this age group (Safe Kids USA, 2005)

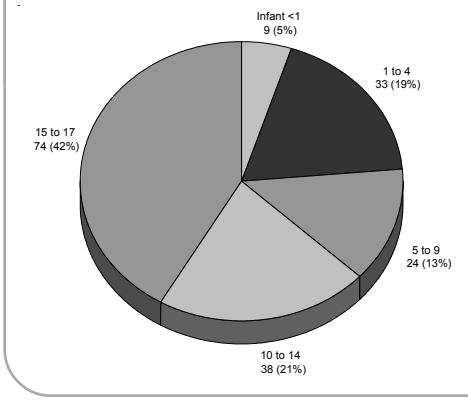
Motor Vehicle-Related Deaths

Motor vehicle-related incidents are the leading cause of death for children over the age of 1 in the U.S. and Georgia. Lack of appropriate restraint use, such as child safety seats, booster seats and seat belts contribute significantly to this problem.
Older adolescents between the ages of 15 and 17 have the highest risk of motor vehicle-related deaths with the primary cause of death being driver error. The combination of exhibiting riskier behavior and having less driving experience adds to this group's risk.

What is included in the definition of motor vehicle-related death?
Deaths attributed to motor vehicle-related incidents include the occupants of the vehicle, drivers and passengers; pedestrians struck by motor vehicles; bicycles and occupants or riders of any other form of transportation (ATV, go-carts, motorized scooters, etc.).

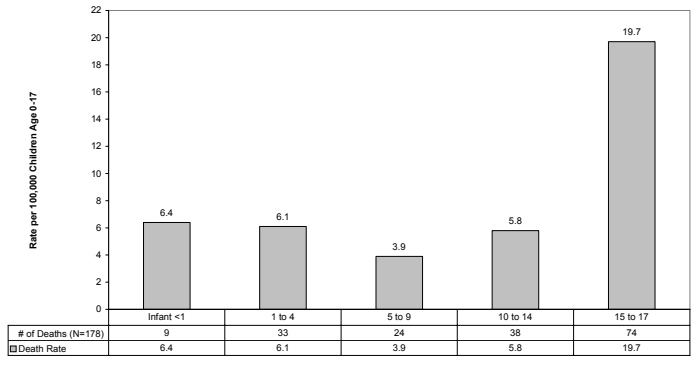
How does GA compare with the U.S. average?
Georgia's unintentional motor vehicle crash fatality rate of 9.9 per 100,000 population is consistent with the national rate of 9.86 utilizing the same parameters. As with many other states, motor vehicle incidents are the leading cause of death due to unintentional injuries.

Figure 19a: Reviewed Motor Vehicle-Related Deaths by Age, 2004 (N=178)



Figures 19a and b show the rates and number of deaths by age category for the 178 children who died in motor vehicle incidents in 2004.

Figure 19b: Reviewed Motor Vehicle-Related Deaths by Age and Rate per 100,000 Population, 2004 (N=178)



	Infant <1	1 to 4	5 to 9	10 to 14	15 to 17
# of Deaths (N=178)	9	33	24	38	74
Death Rate	6.4	6.1	3.9	5.8	19.7

Findings:

- Older adolescents between the ages of 15 and 17 have the highest risk of motor vehicle-related deaths; they are 5 times more likely to have a motor vehicle-related death than the age group with the lowest rate (children between the ages of 5 and 9 years old)
- Infants have the second highest motor vehicle-related death rate with 6.4 deaths for every 100,000 infants
- Children between the ages of 1 and 4 years old have a risk similar to infants, with 6.1 deaths for every 100,000 children in that age group

"A 6-year-old child was riding with her father on an ATV when he lost control and crashed. Both father and child were ejected. The child hit a tree; she died 2 days later from severe head injuries."

Figure 20: Reviewed Motor Vehicle-Related Deaths by Restraint Use and Age, 2004

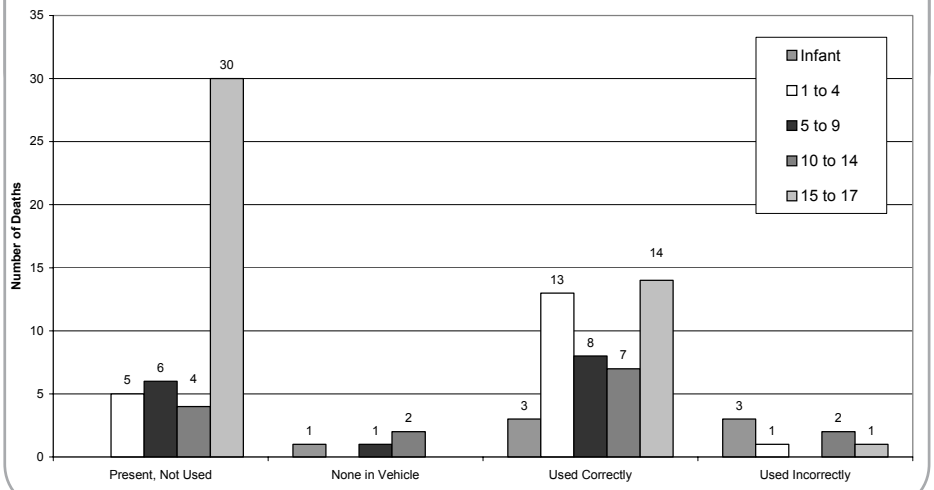


Figure 20 shows motor vehicle restraint use by age group for children who died in motor vehicle incidents in 2004. We do not have information on the accuracy of installation of child safety seats for the decedents.

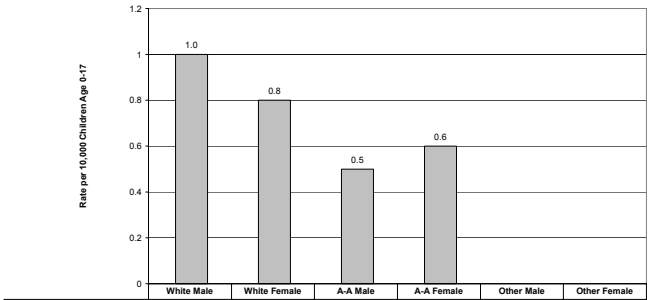
Findings:

- 6 (67%) of the 9 infants who died were in car seats (information unavailable for 2 deaths)
- 14 children ages 1 to 4 years old (74%) were restrained in car seats
- For children ages 5 to 9 years old, 7 of 15 children with available information (47%) were not using a restraint (booster seat or seat belt, depending on age and weight)
- 9 (60%) children ages 10 to 14 years old were using seat belts
- 30 (67%) of the 45 children ages 15 to 17 years old for whom information was available were not wearing seat belts

Facts:

- Effective July 2004, the child passenger safety law was changed requiring children ride in a child safety restraint up to the age of 6. As children grow out of seats that have harness systems, children should graduate into booster seats because adult seat belts are not designed for children
- Only 33% of high school students report they always wear seat belts when riding with someone else
- The Teenage and Adult Driver Responsibility Act (TADRA), is Georgia's graduated driver's license program for young drivers ages 15 to 18, that seeks to decrease crash rates among teen drivers
- Using safety equipment is not a quarantee for surviving a crash, it only improves the odds. Some crashes are simply not survivable due to excessive speed and the consequent forces exerted on the human body; this is particularly true of the most vunerable passengers, such as infants.

Figure 21: Reviewed Motor Vehicle-Related Deaths by Race, Gender and Rate per 10,000 Children Age 0-17, 2004 (N=178)



	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female
# of MVC Deaths (N=178)	74	52	22	25	4	1
MVC Death Rate	1.0	0.8	0.5	0.6		

Figure 21 shows rates and number of motor vehicle-related deaths by race and gender for the 178 children who died in motor vehicle incidents in 2004.

Findings:

- White children are at higher risk than African-American children of dying in a motor vehicle-related incident
- White males have the highest rate of motor vehicle-related deaths, with one death for every 10,000
- African-American males have the lowest rate of motor vehicle-related deaths, with a rate that is half of that seen for White males

Figure 22: Motor Vehicle-Related Deaths by Position at Time of Injury, 2004 (N=178)

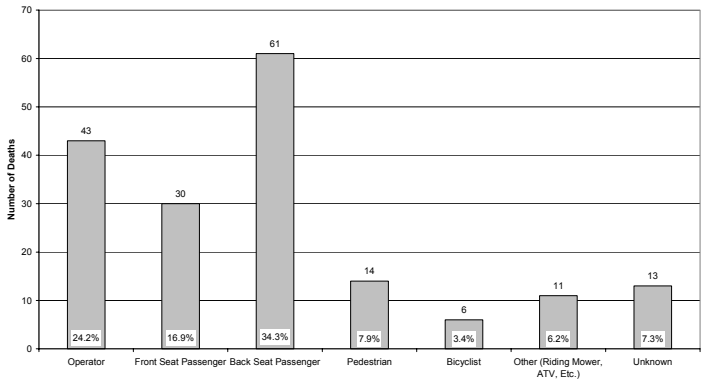


Figure 22 shows the position within or outside the vehicle for the 178 children who died in motor vehicle incidents in 2004.

Findings:

- The most common position for children who died in motor vehicle incidents was in the back seat (34%)
- The second most common position was for the child to be the vehicle operator – 43 children or 24% of all child motor vehicle deaths. Of the 43 children operating vehicles, eight were 14 years old or younger
- 30 children (17%) were passengers in the front seat of the vehicle. Seven (7) of the children were 9 years old or younger

Fact:

- Although the back seat is the safest position for children under the age of 13, back seat placement must be combined with proper restraint use

Figure 23: Reviewed Motor Vehicle-Related Death Rate (per 10,000 Children Age 0-17) by Rural versus Urban Locale, 2004

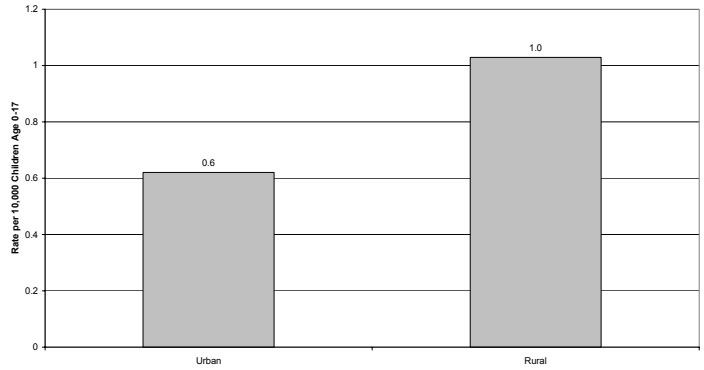


Figure 23 shows whether the motor vehicle incident in which children died occurred in a rural or urban setting.

Finding:

· Children in rural settings were 1.7 times more likely to be involved in a motor vehicle-related death than children in urban settings

Facts:

· Rural roads present a different driving environment as they are often two lanes and more narrow, without the safeguards found in metropolitan areas

· There is a shortage of pediatric trauma care units in Georgia. Children severely injured in areas without pediatric trauma units may have to be transported to another hospital for definitive care

Figure 24: Motor Vehicle-Related Deaths per 100,000 Teens Age 15-17, Three Year Moving Average, 1994-2004 (Based on OASIS Data)

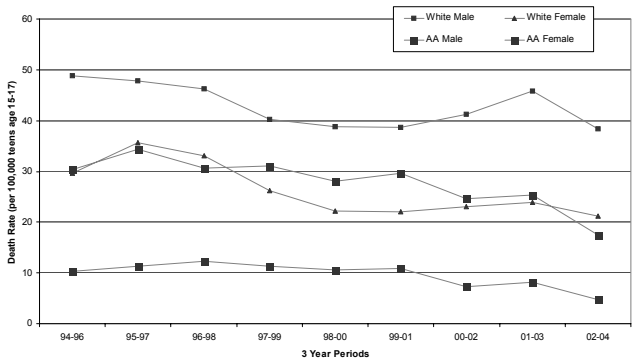


Figure 24 shows 10-year trends in motor vehicle-related death rates by race and gender for teens between the ages of 15 and 17 years old.

Findings:

· Overall, motor vehicle-related death rates among adolescents between 15 and 17 years old have decreased by 27.6% over the ten year period

· The percent of decrease in motor vehicle-related deaths was greater for African-Americans (45.2%) than for Whites (24.1%)

"A 17-year-old boy was the unrestrained driver of a car that left the roadway and collided with a tree. The car caught fire. His death is attributed to blunt force trauma of the torso. Approximately 3 1/2 months earlier he had been the unrestrained occupant in another motor vehicle incident."

Opportunities for Prevention:

For parents

- Children 13 years old and younger should always ride, appropriately restrained, in the back seat of all passenger vehicles- particularly vehicles with airbags
- Ensure that child safety seats are properly installed in a vehicle by reading both the car or vehicle owner's manual, and the directions with the child safety seat, as well as taking the vehicle to an approved inspection site with a licensed technician to insure proper installation
- Parents should instruct/model proper driving behavior for their children, such as wearing a seatbelt on every trip regardless of distance

For community leaders and policy makers

- Community leaders should assure enforcement of existing child restraint laws
- Consider "offenders programs" through the court system as an educational alternative to fines
- Strengthen existing graduating licensing laws to include increased limits on the number of teen passengers allowed in a car with teen driver
- Review and revise current policies and safety programs for ATVs (there were 8 ATVs deaths in 2004)
- Start or support child safety seat distribution and education programs, such as those provided by health departments and Safe Kids Coalitions

For professionals

- Encourage a multifaceted approach to teaching teen drivers through schools and parent/teacher organizations

Resources:

National Highway Transportation Safety Administration
http://www.nhtsa.dot.gov/

SAFE KIDS of Georgia
http://www.choa.org/safety/safekids.html

American Academy of Pediatrics
http://www.aap.org/family/carseatguide.htm

Governor's Office of Highway Safety
http://www.gohs.state.ga.us/

Drowning Deaths

Drowning remains the second leading cause of unintentional injury-related death among children ages 1 to 14. Each year more than 800 children drown in the United States, about 40 % of them in backyard swimming pools. Toddlers who have a natural curiosity and lack of fear are at the greatest risk. Lack of supervision and improper barriers to bodies of water contribute greatly to this problem.

What is characterized as a drowning death?
Drowning deaths occur from water-related submersion and suffocation, and include deaths involving public and private swimming pools, natural open water (rivers, lakes, oceans, and ponds), bathtubs and other bodies of water. Drainage ditches and septic tanks have also been included.

How does GA compare with the U.S. average?
Nationally, White and African-American adolescent males are most likely to drown in males attributable to high rates of drowning in swimming pools. Georgia's drowning death trend for children is similar to the national trend, and remains a leading cause of childhood injury-related death.

Figure 25a: Reviewed Drowning Deaths by Age, 2004 (N=47)

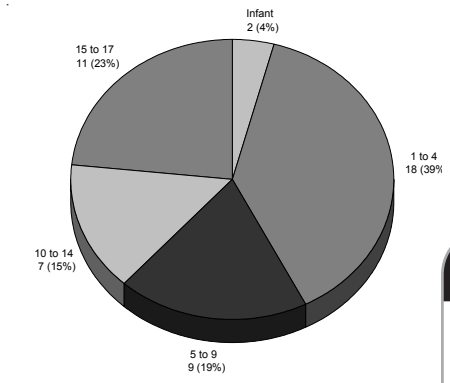
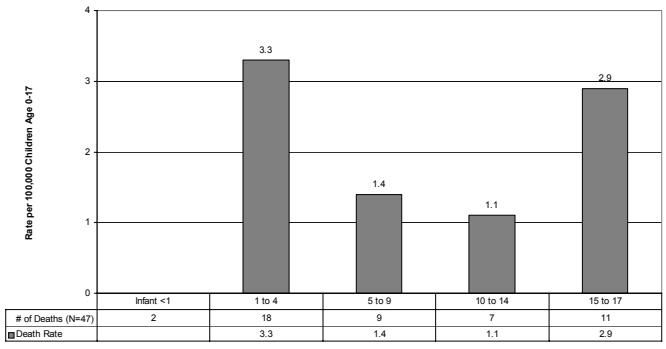


Figure 25b: Reviewed Drowning Deaths by Age and Rate per 100,000 Children Age 0-17, 2004 (N=47)



	Infant <1	1 to 4	5 to 9	10 to 14	15 to 17
# of Deaths (N=47)	2	18	9	7	11
Death Rate		3.3	1.4	1.1	2.9

Figures 25a and b show the rates and number of death by age category for the 47 children who drowned in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

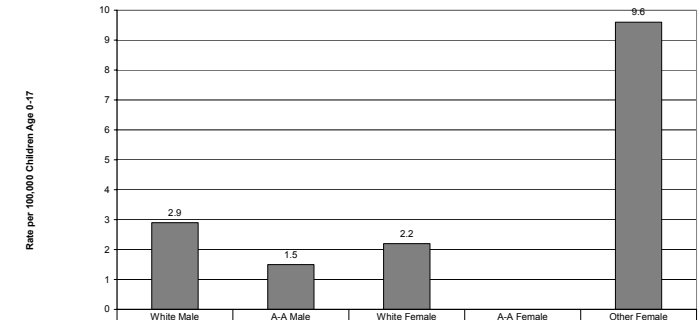
Findings:

- Children in the 1 to 4 year old age group had the highest rate of drowning, with 3.3 deaths for every 100,000 children
- 5 (56%) of the drowning deaths for children ages 5 to 9 years old happened in natural bodies of water
- 6 (86%) of the drowning deaths for children ages 10 to 14 years old occurred in natural bodies of water
- Children ages 15 to 17 years old had the second highest rate of drowning deaths, with 2.9 deaths for every 100,000 children

Facts:

- Drowning is a quick and silent death (children can lose consciousness in 2 minutes with irreversible damage occurring within 4-6 minutes)
- Although drowning among infants younger than 1 year old typically occurs in residential bathtubs, drowning can also occur in places where as little as one inch of water is present (i.e. wading pools, buckets, ditches, toilets and hot tubs). Constant supervision of children near water is key to reducing drowning deaths

Figure 26: Reviewed Drowning Deaths by Race, Gender and Rate per 100,000 Children Age 0-17, 2004 (N=47



	White Male	A-A Male	White Female	A-A Female	Other Female
# of Deaths (N=47)	21	10	9	2	5
Death Rate	2.9	1.5	2.2		9.6

Figure 26 shows rates and number of deaths by race and gender for the 47 children who died from drowning in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

Findings:

- White children are at higher risk of drowning than African-American children
- Males have higher rates of drowning than females
- White males have the highest rate of drowning deaths, with 2.9 deaths for every 100,000 White males

Facts:

- Among males 5 to 17 years of age, drowning rates are higher among African-American males than among White males
- Among females, drowning rates peak at 1 to 2 years of age and decrease thereafter. Among males, there are peaks in both the toddler and adolescent age groups

Figure 27: Deaths Due to Drowning in Pools and Bathtubs by Month of Occurrence, 2004 (N=23)

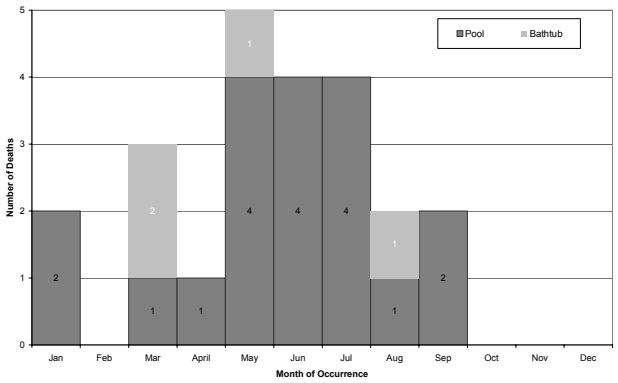


Figure 27 shows the month of occurrence for the 23 deaths that occurred in swimming pools and bathtubs.

Finding:

- Swimming pool deaths are clustered in the spring and summer, with all deaths but two happening between March and September

Facts:

- Among drowning victims younger than 15 years, two thirds of deaths occur from May through August. Drowning also occurs disproportionately on Saturdays and Sundays
- Most young children who drowned in pools were last seen in the home, had been out of sight less than five minutes, and were in the care of one or both parents at the time
- 19% of drowning deaths involving children occur in public pools with certified lifeguards present

Figure 28: Drowning Death Rates per 100,000 Children Age 0-17, Three-Year Moving Average, 1994-2004 (Based on OASIS Data)

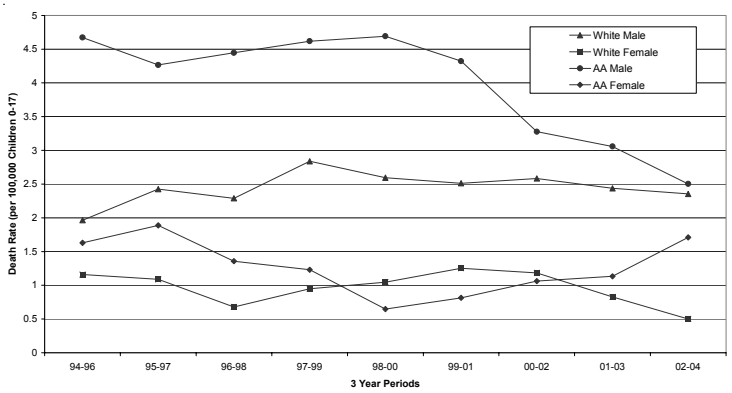


Figure 28 shows 10-year trends in drowning rates by race and gender.

Findings:

- Over the last ten years, an average of 45 children have drowned each year in Georgia
- While African-American males have the highest rates of drowning, they have also had the greatest decline in drowning deaths
- The rate for African-American males has gone down by 52%, and the rate for African-American females has gone down by 77%
- The rate for White males has remained constant and the rate for White females has decreased slightly over the ten years

Opportunities for Prevention:

For parents

- Implement use of safety devices designed to avert outdoor drowning dangers such as water motion sensors for pools/hot tubs as well as establishing effective barriers around ponds and open bodies of water
- Never leave infants unattended; drowning can occur in places where as little as one inch of water is present (i.e. wading pools, buckets, ditches, toilets and hot tubs)
- Supervise small children at play near pools, on boats and in the home
- Consistently use Coast Guard-approved Personal Flotation Devices (PFDs) for themselves and their children when involved in water-related recreational activities
- Learn CPR
- Participate and encourage children taking swimming lessons

For community leaders and policy makers

- Advocate for community-wide swimming lessons/water safety instruction for children beginning at a young age by a certified swimming instructor
- Empower, implement and enforce local ordinances for 4-sided isolation fencing at least 5 feet high and equipped with self-closing, self-latching gates for public and private pools statewide
- Reinforce the need for constant adult supervision for children engaging in water-related activities by an individual who can swim and is knowledgeable in basic rescue techniques, including CPR

For professionals

- Raise awareness of indoor safety devices which can help delay a toddler's access to dangers in the home, including: baby gates and door-knob covers as barriers to bathrooms, kitchens, garages, and toilet cover locks
- Promote awareness of safety devices which can be used to avert outdoor drowning dangers, including: fencing with self-latching gates around pools and hot tubs, water-motion sensors for pools/hot tubs, as well as establishing effective barriers around ponds and open bodies of water
- Encourage parents/caregivers to consistently use Coast Guard-approved Personal Flotation Devices (PFDs) for themselves and their children when involved in water-related recreational activities

Resources:
American Academy of Pediatrics
http://www.aap.org/family/tipppool.htm

American Red Cross
http://www.redcross.org/services/bss/tips/healthtips/safetywater.html

National Safety Council
http://www.nsc.org/library/facts/drown.htm

U.S. Coast Guard, Office of Boating Safety

http://www.uscgboating.org/

The United States Lifesaving Association
http://www.usla.org/index.html

Fire-Related Deaths

Fire and burns are the fifth leading cause of unintentional injury-related death among children ages 14 and under.

In Georgia, most of the fire-related incidents included the death of more than one child. Fires occurred most commonly in wood frame construction (45%), and trailers (7%). Only 11 deaths (27.5%) occurred when a working smoke alarm was known to be present. Smoke alarms dramatically increase a child's chance of surviving a fire. It is estimated that nearly half of all residential fires and 60% of fatalities occur in homes with no smoke alarms.

What is included in the definition of fire-related death?
A fire-related death is one resulting from fire- or burn-related injuries sustained in a fire, and includes deaths from smoke inhalation.

How does GA compare with the U.S. average?
Georgia had 40 fire-related child fatalities in 2004. The South has the highest fire-related death rate in the country – 21% higher than the national average.

Figure 29a: Reviewed Fire-Related Deaths by Age, 2004 (N=40)

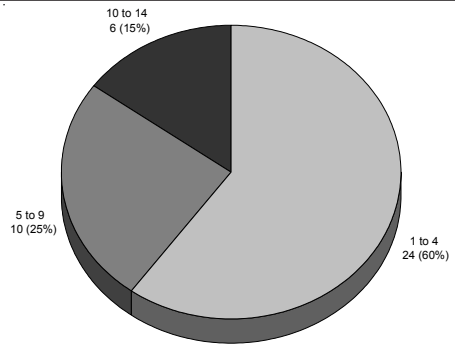
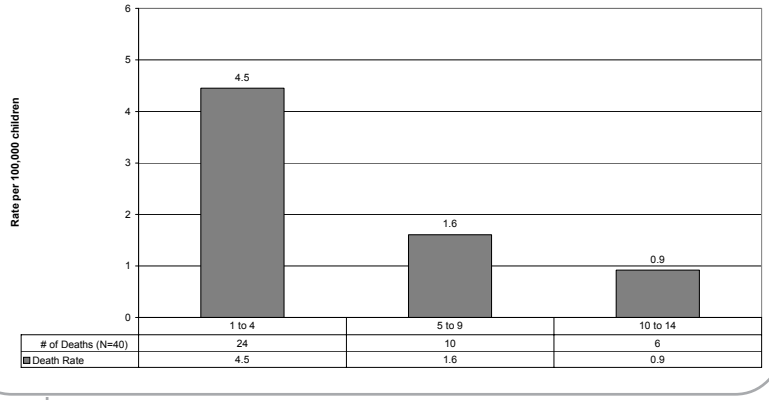


Figure 29b: Reviewed Fire-Related Deaths by Age, and Rate per 100,000 Children, 2004 (N=40)



Figures 29a and b show the rates and number of deaths by age category for the 40 children who died from fire-related causes in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

"Child was trapped in her home when a fire occurred. Parents attempted to get child out but were unable to get to her room. Two other children and two parents escaped. No smoke dectors were in the home."

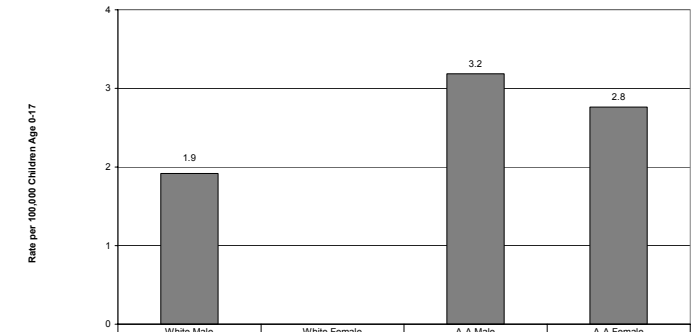
Findings:

- There were no fire-related deaths among infants or older teens (15 and 17 years of age)
- Among children between 1 and 14 years old, the rate of death decreased with age
- Twenty-four children between 1 and 4 years old died in fires, with a rate of 4.5 deaths for every 100,000 children in this age group. This rate is five times higher than the rate for young adolescents between 10 and 14 years old

Facts:

- In the South, young children, particularly those ages 5 and under, are at greatest risk for home fire-related death and injury, with a fire death rate more than twice the national average
- Young children have a limited ability to react promptly and rationally to a fire. More than half the children under the age of 5 who die in home fires are asleep at the time (Safe Kids Worldwide)

Figure 30: Reviewed Fire-Related Deaths by Race, Gender and Rate per 100,000 Children Age 0-17, 2004 (N=40)



	White Male	White Female	A-A Male	A-A Female
# of Deaths (N=40)	14	2	13	11
Death Rate	1.9		3.2	2.8

Figure 30 shows rates and number of deaths by race and gender for the 40 children who died from fire-related causes in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

Findings:

- African-American children are at higher risk of fire-related deaths than White children
- African-American males have the highest rate of fire-related deaths (3.2 deaths for every 100,000); and African-American females have a similar rate of death as African-American males (2.8 deaths for every 100,000)
- 14 White males died from fire-related causes, with a rate of 1.9 deaths for every 100,000 White males

Figure 31: Reviewed Fire-Related Death Rate (per 100,000 Children Age 0-17) by Rural versus Urban Locale, 2004

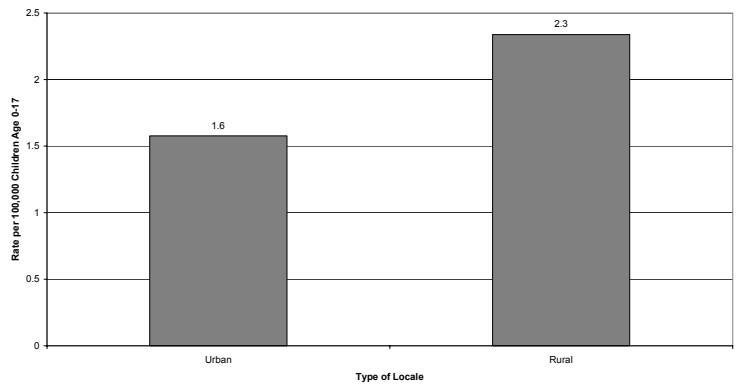


Figure 31 shows the number of fire-related deaths for urban and rural areas and the rates per 100,000 children younger than 18 years old living in those areas.

Findings:

- 30 fire-related deaths were in rural areas and 10 were in urban areas
- The rate of death from fire-related causes was 1.5 times higher in rural areas than in urban areas (2.6 vs. 1.3 per 100,000 children.)

Fact:

- Only 23% of households in the U.S. have actually developed and practiced a home fire escape plan to ensure they could escape quickly and safely (National Fire Prevention Association, 2005)

Figure 32: Fire-Related Death Rates per 100,000 Children Age 0-17, Three-Year Moving Average, 1994-2004 (Based on OASIS Data)

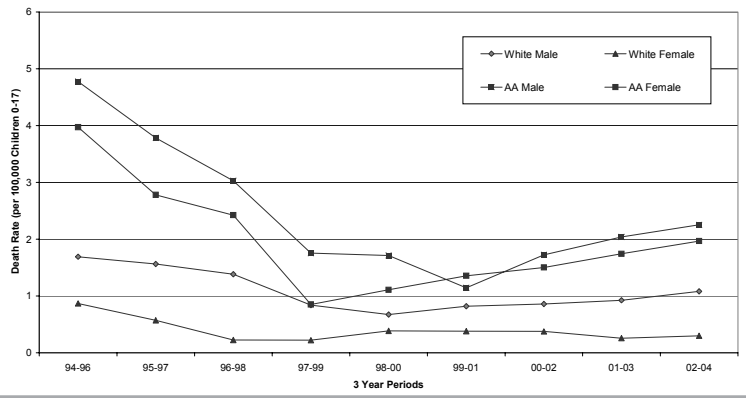


Figure 32 shows 10-year trends in rates of fire-related deaths by race and gender.

Findings:

- Both the number and rate of fire-related deaths have decreased over the last ten years
- Rates of death have decreased most sharply among African-Americans (by 53% among males and 51% among females)

Opportunities for Prevention:

For parents

- Properly install smoke detectors on every level of home and in every sleeping area
- Test smoke alarms once a month and replace batteries as needed. Replace smoke detectors every 10 years
- Store matches and lighters out of children's reach and supervise children's use of candles
- Create and practice an escape plan for exiting the home in the event of a fire

For community leaders and policy makers

- Encourage local fire marshals to enforce home safety regulations
- Fund smoke detectors for at-risk homes. At-risk homes usually comprise older construction, wood frame houses and occupants that include smokers, the elderly, or children
- Support programs which promote all families having a smoke detector and fire escape plan

For professionals

- Target high risk areas with smoke detector programs
- Implement a multi-faceted community campaign to prevent burn injuries. Target well-defined population with well defined message
- Encourage training for families to develop and implement escape plans

Resources:

National Fire Protection Association
http://www.nfpa.org/

SAFE KIDS Worldwide
http://www.safekids.org

Georgia Firefighters Burn Foundation
http://www.gfbf.org/

U.S. Fire Administration
http://www.usfa.fema.gov/public/

Intentional Injury

In 2004, the total number of deaths reviewed by committees resulting from homicide (74) and suicide (26) was a slight decrease from the number of deaths resulting from those causes in 2003 (101). In 2004, local child fatality review committees reviewed a total of 100 deaths determined to have resulted from intentional causes. Though death certificate data indicated "suicide" as the cause of death in 24 cases, committees determined 2 more deaths were the result of suicide than those indicated on death certificates.

What is included in the definition of "intentional injury"?
Intentional injuries are those incurred when one person deliberately causes harm to himself, herself or another person. This includes assault, battery, self-inflicted injuries, suicide and homicide. It also includes a willful, wanton, or reckless disregard for the safety of others during the course of action (for example, a child killed by a stray bullet).

Homicide

Homicide is the leading cause of injury deaths among infants (under one year of age) in the United States. Infants are most likely to be killed by their mother during the first week of life, but are more likely to be killed by a male (usually their father or stepfather) thereafter. Half of all infant homicides occur by the fourth month of life, with the risk being greatest on the day of birth. Homicide risk is greater in the first year of life than in any other year of childhood before age 17.

How does Georgia compare with the U.S. average?
The death rate from homicide in Georgia has been consistently higher than the national average since 1979, though both have decreased over time. Infants and 15 – 17 year old teens have the highest homicide rates of all age groups in Georgia. Georgia's homicide rate (per 100,000 children in the population) is 3.29, while the U.S. rate is 2.49 per 100,000 children.

In 2004, child fatality review committees reported 74 homicide deaths, which is a 4% increase from 2003 (71). The figure below represents reviewed homicide deaths by circumstance of death.

Figure 33: Reviewed Homicide Deaths by Mechanism of Injury, 2004 (N=74)

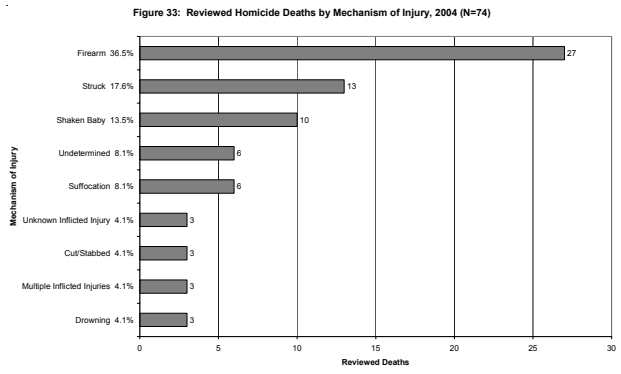


Figure 33 shows the mechanism of injury for the 74 children whose deaths were homicides in 2004.

Findings:
- Firearms were determined to be involved in 27 (36%) of the 74 homicide deaths
- 23 deaths (31%) were attributed to blunt force trauma or violent shaking (shaken/impact)

Fact:
- The majority of fatal injury deaths among infants is due to abusive head trauma, also known as Shaken Baby/Shaken Impact Syndrome, which occurs when an infant is violently shaken or thrown against a hard surface

Figure 34a: Reviewed Homicide Deaths by Age, 2004 (N=74)

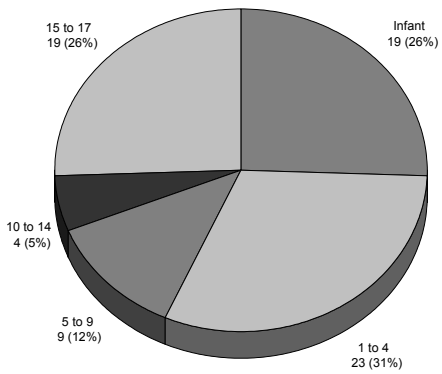
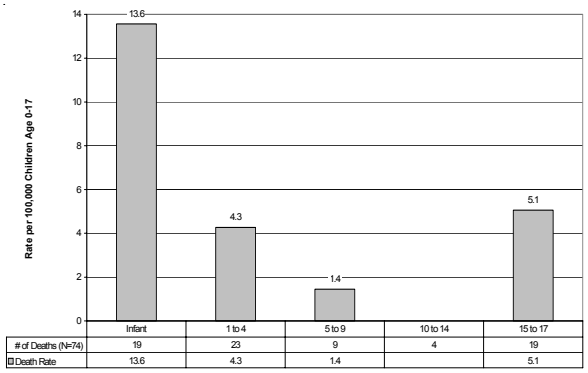


Figure 34b: Reviewed Homicide Deaths by Age and Rate per 100,000 Children Age 0-17, 2004 (N=74)



Figures 34a and b show the rates and number of deaths by age category for the 74 children whose deaths were homicides in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

Findings:

- 26 % of the 74 reviewed homicides were youth ages 15 to 17 (with 14 of the 19 homicides caused by a firearm)
- 57% of homicide victims were younger than 5 years of age (with 23 of the 42 homicides caused by shaking and/or blunt force trauma)

Fact:

- Homicide rates for children decrease between ages 1 – 14, particularly after reaching school age

Figure 35: Reviewed Homicide Deaths by Race, Gender and Rate per 100,000 Children Age 0-17, 2004 (N=74)

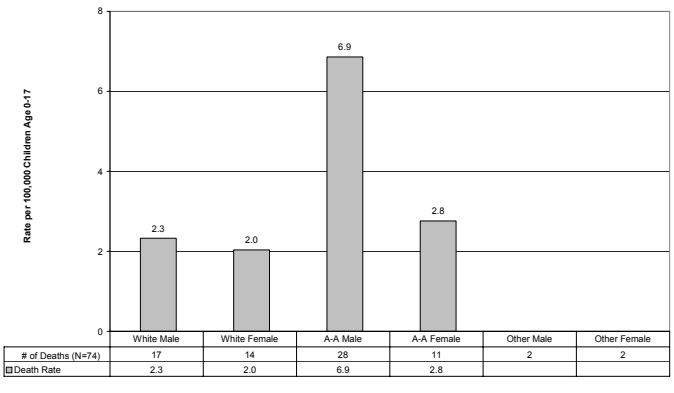


Figure 35 shows rates and number of homicide deaths by race and gender in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

"An 18-month-old Hispanic male was killed by his mother's boyfriend, who admitted the child would not stop crying. He picked the child up, covering his mouth and nose, shook the child violently, and hit him on the head with his hand"

Findings:

- African-American children had the highest rates of homicide deaths. Overall, 39 African-American children were victims of homicide (4.8/100,000), while 31 White children were victims of homicide (2.3/100,000)
- Males have higher rates of homicide than females. In 2004, 47 males and 27 females were victims of homicide. The rates were 3.9/100,000 males and 2.3/100,000 females.
- African-American males had the highest rate of homicide deaths. The African-American male rate of 6.9/100,000 is 3.5 times higher than the rate of 2.0/100,000 for White females. White females have the lowest rate of homicide

Fact:

- The national homicide rate for African-American male teens was 53.3 per 100,000, nearly 14 times higher than the rate for White males (3.9 per 100,000). African-American females also have the highest homicide rate at 8.0 per 100,000, compared with 1.6 for White females

Figure 36. Homicide Death Rates per 100,000 Teens Age 15-17, Three-Year Moving Average, 1994-2004 (Based on OASIS Data)

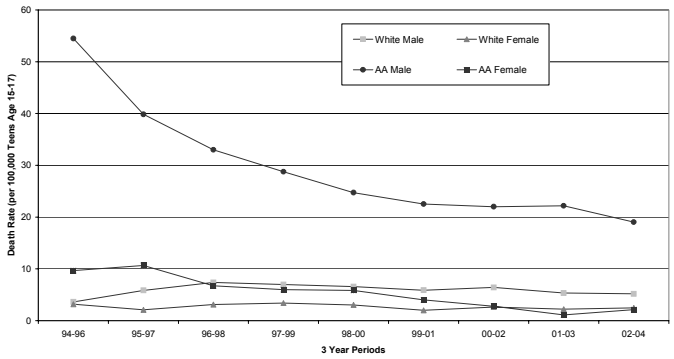


Figure 36 shows 10-year trends in homicide rates by race and gender for teens between the ages of 15 and 17 years old.

Findings:

- Overall, homicide rates among children have decreased by 67.1% over the ten-year period (the number of homicides decreased from a high of 50 in 1994 to 20 in 2004)
- Most of the decrease has occurred among African-American males. This rate decreased by 81.7% (from a high of 74.3 in 1994 to 13.1 in 2004)
- African-American males (15-17) make up 18 % of the teen population, but account for 45% of all teen homicides
- White males were the only group to show an increase in the rate of homicide during this time period (from 3.6 in 1994 to 5.3 in 2004, an increase of 42.8%)

Fact:

- Older teens (ages 15–17) are more likely to be victims of homicide than younger teens (ages 12–14)

Opportunities for Prevention:

For parents

- Learn and teach children anger management skills, and demonstrate behavior which devalues bullying and violence
- Reduce access to lethal means by providing secure storage for firearms
- Never shake an infant. Reach out for help when feeling overwhelmed or stressed

For community leaders and policy makers

- Support legislation and programs promoting responsible gun ownership, including the use of firearm safety locks and secure firearm storage
- Increase support for violence prevention programs
- Implement programs to assist overwhelmed parents and caregivers with childcare issues
- Provide alternative after-school programs for children

For professionals

- Promote in-school and after-school programs teaching conflict resolution, impulse control, anger management and empathy (e.g. Second Step – violence prevention program)
- Develop and implement programs that educate the safe use and storage of firearms, and reduce bullying
- Educate new parents and caregivers about the dangers of shaking an infant, and appropriate methods of coping

Resources:

National Youth Violence Prevention Resource Center
http://www.safeyouth.org/

National Center for Victims of Crime
http://www.ncvc.org

National Center for Injury Prevention and Control (NCIPC)
http://www.cdc.gov/ncipc/

Suicides

Each year in the United States, thousands of teenagers commit suicide. There has been a significant increase in youth suicide, over 300% since 1950. Suicide is the third leading cause of death for 15-19 year olds, and the sixth leading cause of death for 5-14 year olds. While the suicide rate for high school students has remained relatively constant for the past ten years, of particular concern to educators is the suicide rate for middle school students (age 10-14), which has increased more than 100% during the same time period.

Mood disorders such as depression, dysthymia, and bipolar disorders are major risk factors for suicide among children and adolescents. One study found that over 90 percent of the children and adolescents who committed suicide had a mental or mood disorder (Report of the Surgeon General on Mental Health). Stressful life events and low levels of communication with parents may also be significant risk factors. Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools, and communities. While female teens are about twice as likely to attempt suicide (often leading to hospitalization), males are much more likely to actually complete a suicide. Males are four times more likely to die from suicide than females, with rates highest among Whites.

What is the definition of suicide?

Suicide is the act of voluntary and intentional self-harm (by asphyxia/suffocation, cutting, poisoning, firearms or falls), which results in death.

How does Georgia compare with the U.S. average?

The death rate from suicide in Georgia (1.1 per 100,000) is similar to the U.S. suicide death rate (1.34). The suicide rates for both Georgia and the U.S. have remained almost unchanged over the past twenty years. In 2004, there were 26 youth suicides in Georgia, indicating a 15% decrease from 2003 (30).

Figure 37: Reviewed Suicide Deaths by Method of Death, 2004 (N=26)

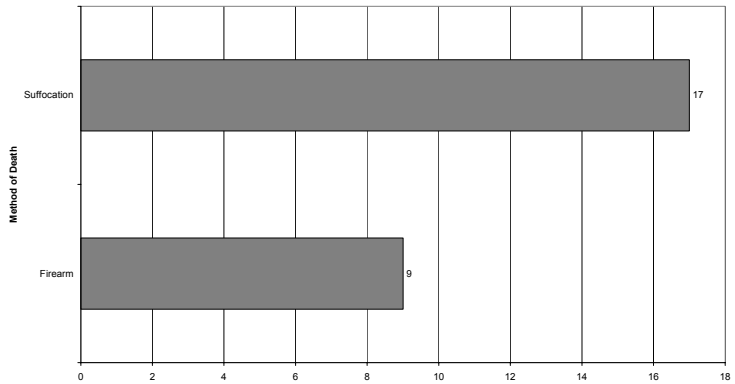


Figure 37 shows the manner of death for the 26 children who committed suicide in 2004.

Findings:

- Firearms were determined to be involved in 9 (35%) of the 26 suicide deaths
- 17 suicide deaths (65%) were attributed to hanging or suffocation

Facts:

- Approximately 1,200 children and teens commit suicide with a firearm each year in the U.S.
- Homes with firearms are five times more likely to have a suicide than homes without

Figure 38: Reviewed Suicide Deaths by Age, 2004 (N=26)

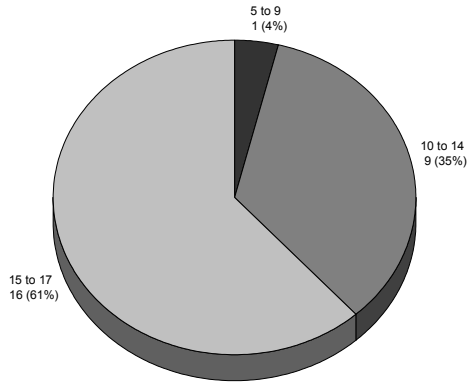


Figure 38 shows the ages of the 26 children who committed suicide in 2004.

Findings:

- 16 (62%) of the 26 reviewed suicides were children ages 15 to 17
- 9 children (35%) were between the ages of 10 and 14 years old
- 1 child was eight years old

Fact:

- A far greater number of youths attempt suicide than complete suicide each year. Suicide attempts are difficult to count, because many may not be treated in a hospital or may not be recorded as self-inflicted injury

"A 16-year-old White male had an argument with his parents and became angry when they refused to take him to get his driver's license. He hung himself in their backyard."

Figure 39: Reviewed Suicide Deaths by Race and Gender, 2004 (N=26)

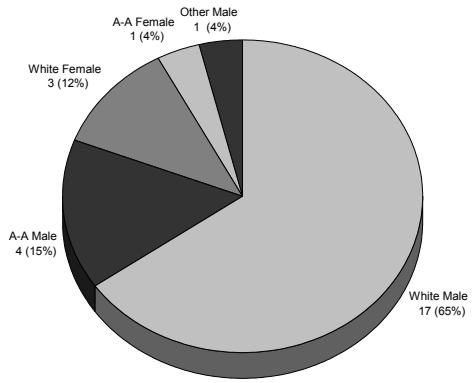


Figure 39 shows the number of suicide deaths by race and gender in 2004.

Findings:

- Almost all of the suicide deaths were males (22 of 26)
- White children (20) were 4 times more likely to commit suicide than African-American children (5)

Fact:

- Historically, African-Americans have had much lower rates of suicides compared to Whites
- If a male has attempted suicide in the past, he is more than 30 times more likely to complete suicide, while a female with a past attempt has about 3 times the risk

Figure 40: Suicide Death Rate per 100,000 Teens Age 15-17, Three Year Moving Average, 1994-2004 (Based on OASIS Data)

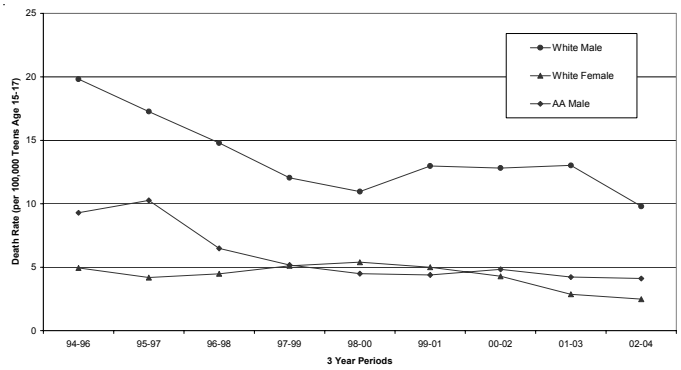


Figure 40 shows 10-year trends in suicide rates by race and gender for teens between the ages of 15 and 17 years old.

Findings:

- White males are 5 times more likely than all other teens to be a suicide victim (1998-2004)
- White males (15-17) make up 32 % of the teen population, but account for over 62% of all teen suicides
- Overall, suicide rates among children have decreased by 51% over the last ten years

Fact:

- Approximately one-third of teenage suicide victims have made a previous suicide attempt in the past

Opportunities for Prevention:

For parents

- Reduce risk factors for self-harm or injury by reducing access to firearms
- Provide support services for youth experiencing stress, confusion, depression, substance abuse, and/or behavioral problems
- Monitor children for changes in behavior, e.g., loss of interest in favorite things, changes in school performance, withdrawal from friends and family

For community leaders and policy makers

- Provide training for teachers, school personnel and health department staff about suicide risk assessment and referral resources
- Increase access to mental heath services

For professionals

- Educate parents on effective supervision of children and adolescents
- Implement protocols to support youth following a suicide attempt
- Organize and involve local communities in suicide prevention planning
- Reduce stigma associated with suicide. Provide a safe place for children and teens to share their problems and concerns

Resources:

Georgia Suicide Prevention Plan
http://georgiasuicidepreventionplan.org/

Suicide Prevention Action Network
http://www.spanusa.org/GSPP.html

The National Suicide Hotline
1-800-SUICIDE (1-800-784-2433)

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov

Firearm-Related Deaths

Nationally, firearms were the instruments of death in over 80% of teen homicides. They are responsible for 77% of violent deaths in schools. For every child killed by a firearm, four more seek medical care for injury. On an annual average, firearms kill 5,285 children in the United States.

What is included in the definition of "firearms"?
A firearm is any weapon that fires a high-velocity projectile, and includes rifles, pistols, revolvers, shotguns, handguns, and BB guns.

How does Georgia compare with the U.S. average?
At least 25 million American households have handguns and 50% of owners keep them loaded. Overall, fewer than half of the U.S. families with firearms and children store those firearms locked (either in a locked place or secured with a trigger lock) and separate from ammunition. Nearly two-thirds of firearm-owning parents with school-age children believe they keep their firearm safely away from their children. However, one study found that when a gun was in the home, 75-80% of first and second graders knew where it was kept. (Safe Kids USA) And though several states have legislation to regulate child access and usage of firearms, Georgia does not currently provide a Child Access Prevention law, negligent owner law, or a minimum age for possession of rifles or shotguns. In addition, Georgia children under age 18 can possess a firearm if they are at their own residence, and under the control of their parent or guardian.

Child fatality review committees reviewed 44 firearm-related deaths. Child fatality review reports ask for information not available on death certificates, including source of the firearm, type of firearm, who was using the firearm at the time of death, and the age of the firearm handler. This information provides important guidance for prevention.

Figure 41: Reviewed Firearm-Related Deaths by Intent, 2004 (N=44)

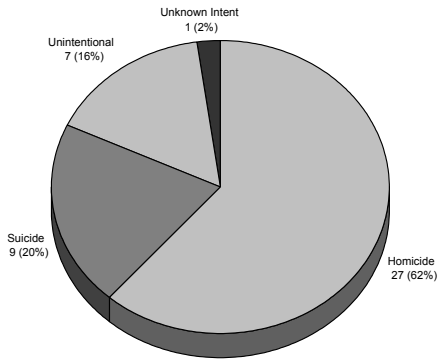


Figure 41 shows the intent underlying the 44 child deaths that were caused by firearms in 2004.

Findings:

- 27 (61%) firearm-related deaths of children were homicide
- An additional 9 (20%) deaths of children from firearms were suicide
- 7 deaths (16%) were determined to be the result of an unintentional use

Facts:

- Many of the documented firearm injuries and deaths are accidents among children who stumble upon a gun in their home and fire it
- In a study of unintentional handgun shootings of children under 16, nearly 40% of the shootings occurred in the homes of friends and relatives, most often when the children were unsupervised

Figure 42a: Reviewed Firearm-Related Deaths by Age, 2004 (N=44)

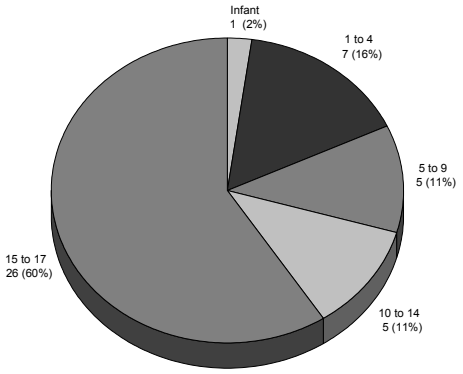
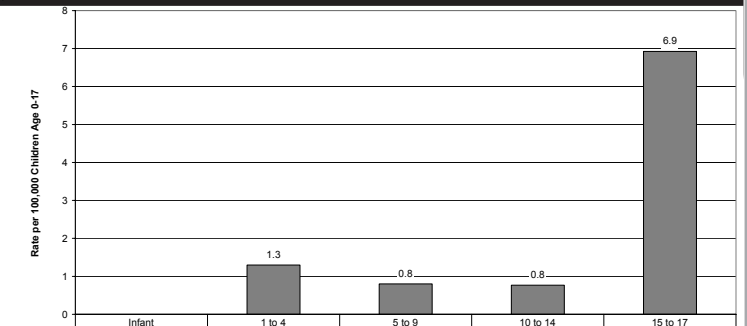


Figure 42b: Reviewed Firearm-Related Deaths by Age and Rate per 100,000 Children Age 0-17, 2004 (N=44)



Figures 42a and b show the rates and number of deaths by age category for the 44 child firearm-related deaths in 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

Findings:

- 26 child firearm deaths occurred among 15 to 17 years old, which was the highest rate: 6.9/100,000
- 7 (16%) child firearm deaths occurred among 1 to 4 year olds, which was the second highest rate (1.3/100,000)

Facts:

- The CDC estimates that 18 youth die from firearms each day in the U.S.
- The overall firearm-related death rate among U.S. children aged less than 15 years was nearly 12 times higher than among children in 25 other industrialized countries combined
- Two-thirds of students in grades 6-12 say they could obtain a firearm in 24 hours

Figure 43: Reviewed Firearm-Related Deaths by Status of Firearm Security, 2004 (N=44)

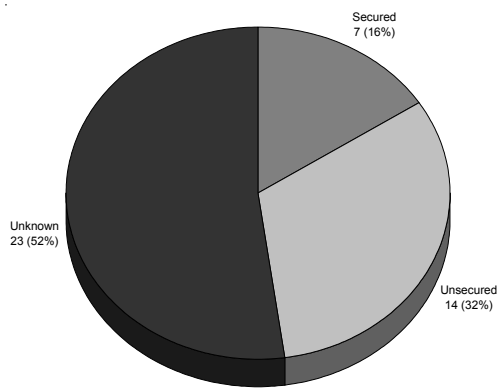


Figure 43 shows whether the firearms involved in the 44 deaths in 2004 were secured. A secured firearm is one that is stored or locked in a location which is potentially inaccessible to children.

Findings:

- It was unknown whether the firearm in 23 (52%) deaths had been secured
- An unsecured firearm was reported in twice as many child deaths (14) when compared to a secured firearm (7)

Facts:

- In the U.S., one quarter of gun-owning households with children reported only "occasionally" locking and storing the bullets in a separate place from the gun
- One study found that 2.6 million children live in households where firearms are stored unlocked and loaded, or unlocked and unloaded with ammunition nearby
- A separate study found that the prevalence of loaded, unlocked guns in rural households was about twice that of urban households

Figure 44: Incident Location for Reviewed Firearm-Related Deaths (N=44)

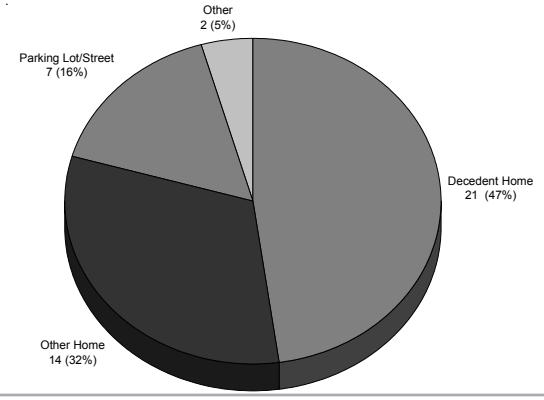


Figure 44 shows the number of child firearm deaths and the location where they occurred

Finding:

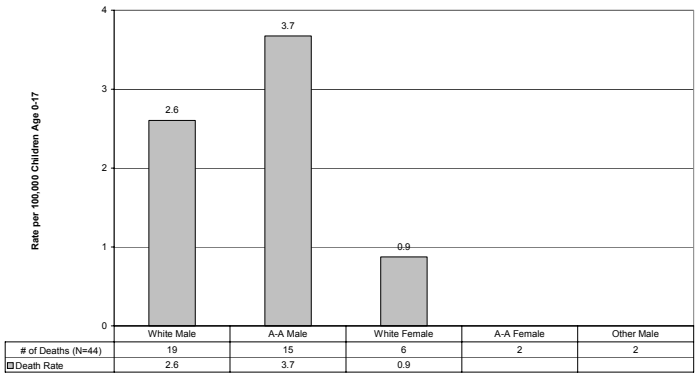
- 35 of the 44 firearm deaths (79%) occurred in the child's home (21), or the home of a friend (14)

Facts:

- Major contributing factors to youth firearm deaths include easy access to handguns
- In 72% of firearm deaths among youth, the firearm was stored in the residence of the victim, a relative, or a friend

"This 11-year-old White male was accidentally shot by his father who had returned from hunting and was in the process of putting up two guns. Father tripped over the dog and accidentally shot child in the head."

Figure 45: Reviewed Firearm-Related Deaths by Race, Gender and Rate per 100,000 Children Age 0-17, 2004 (N=44)



	White Male	A-A Male	White Female	A-A Female	Other Male
# of Deaths (N=44)	19	15	6	2	2
Death Rate	2.6	3.7	0.9		

Figure 45 shows rates and number of firearm-related deaths by race and gender for 2004. Rates are provided to adjust for the relative size of the population and enable meaningful comparisons.

Findings:

- Males are at higher risk of firearm-related death than females. In 2004, 36 males and 8 females were victims of firearms. The firearm-related death rate was 4.1 times higher for males (3.0/100,000) than it was for females (0.7/100,000)
- African-Americans were slightly more likely than Whites to have a firearm-related death (2.1/100,000 compared to 1.8/100,000)
- African-American males had the highest death rate from firearms (3.7/100,000), while African-American females had the lowest rate (0.5/100,000)

Figure 46: Reviewed Firearm-Related Deaths by Type of Firearm, 2004 (N=44)

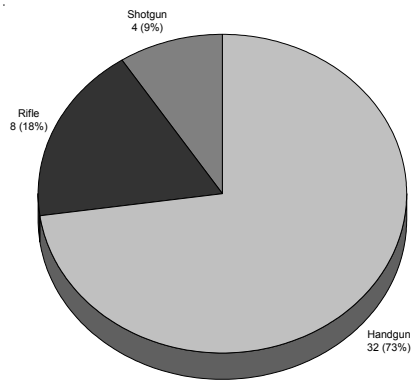


Figure 46 shows the type of firearm involved in the 44 firearm-related deaths in 2004.

Findings:

- 32 (73%) of the firearms involved were handguns
- 8 (18%) children were killed by rifles
- 4 shotguns were involved in firearm deaths (9%)

Fact:

- Overall, youth in the United States have a one in 1,339 chance of being killed by gunfire before the age of 20. For young African-American males, however, the odds are one in 307, while for young White females the odds are one in 6,077

Figure 47. Firearm-Related Death Rate per 100,000 Teens Age 15-17, Three-Year Moving Average, 1994-2004 (Based on Death Certificates)

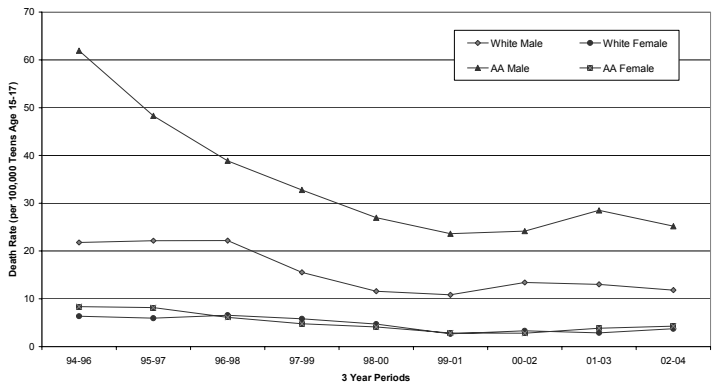


Figure 47 shows 10-year trends in firearm-related death rates by race and gender for teens between the ages of 15 and 17 years old.

Findings:

- Overall, firearm-related death rates among children have decreased by 53.1% over the ten year period from 21.2/100,000 in 1994 to 9.9/100,000 in 2004
- The decrease was the largest among African-American males, whose rate decreased 59.3% from 21.8 to 11.8/100,000

Facts:

- 17-19% of surveyed high school students have admitted to carrying a weapon in the past 30 days (Youth Risk Behavior Survey, 1999, 2001, 2003)
- Nationally, the number of African-American children and teens killed by guns has decreased 55%, and the number for White children and teens has dropped 42%, since 1994

Of the 26 reviewed suicides, 9 (35%) involved firearms:
6 (67%) = handgun
3 (33%) = rifle

Of the 74 reviewed homicides, 27 (36%) involved firearms:
22 (81%) = handgun
2 (7%) = rifle
3 (11%) = shotgun

Usage

- In 97 % of intentional firearm deaths (33) the shooter was aiming at himself or someone else. Seven firearm deaths were unintentional
- African-American children and teens were more likely to be victims of firearm homicide, while their White counterparts were more likely to use a firearm to take their own life

Storage

- The gun was unsecured in 14 of the 21 deaths with information on gun storage

Age of Handler

- The shooter was under age 18 in 16 (53%) of the 30 deaths that identified the age of the shooter

Opportunities for Prevention:

For parents

- Secure all firearms in a safe, secure, and childproof location. Store firearms and ammunition in separate locations
- When handling or cleaning a firearm, never leave it unattended; it should be within sight at all times

For community leaders and policy makers

- Support efforts to limit minors' access to firearms
- Promote development of school and community-based risk reduction firearm safety programs for children, parents and other caretakers

For professionals

- Promote and train gun owners on the use of firearm safety devices, including trigger locks and lock-boxes
- Teach and promote conflict resolution skills as well as personal firearm safety precautions for children

Resources:

Center to Prevent Handgun Violence
www.handguncontrol.org

National Rifle Association Safety Guide for Parents
(http://www.nrahq.org/safety/eddie/infoparents.asp)

Race, Ethnicity and Disproportionate Deaths

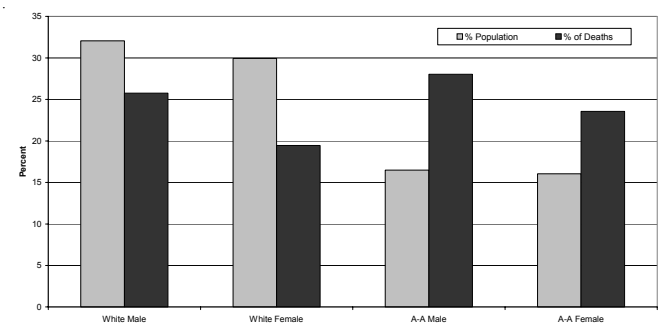
In 2003, there were 73 million children ages 0–17 in the United States (25 % of the population), which was down from a peak of 36 % at the end of the baby boom in 1964 (ChildStats.gov). Children are projected to compose 24 % of the total population in 2020. The racial and ethnic diversity of America's children continues to increase over time. In 2003, 60 % of U.S. children were White-alone, non-Hispanic, 16% were African-American, and 4% were Asian. The proportion of Hispanic children has increased faster than that of any other racial and ethnic group, growing from 9% of the child population in 1980 to 19% in 2003.

The infant mortality rate, on the other hand, has continued to steadily decline over the past several decades. According to the Center for Disease Control a national health objective for the year 2000 was to reduce the infant mortality rate (IMR) in the United States to 7.0 deaths per 1,000 live births among infants younger than 1 year. The national health objective for 2010 targets a rate of 4.5 infant deaths per 1,000 live births. An overarching goal calls for eliminating disparities among racial and ethnic populations. Strategies to reduce IMRs and eliminate disparities among racial/ethnic populations should consider various factors that might differ by race/ethnicity. Such factors might include infant age at death, cause of death, mother's age and health, multiple births, low birthweight, premature births, assisted reproductive technology, prenatal visits, and access to health-care services.

The death certificate provides information on ethnicity of the decedent and can be used to identify the deaths of children of Hispanic origin. Ninety-nine infant and child decedents in 2004 were identified as of Hispanic origin. Ninety-seven of the 99 reported race as "white", and the remaining two reported "African-American". A majority of the Hispanic deaths were infants (64), but the mortality rate for the Hispanic infants (3.3 per 1,000) was much lower than the rate for white, non-Hispanic infants (6.4 per 1,000). The total number of Hispanic infant deaths was down from 92 in 2003, and the number of Hispanic deaths, ages 1 to 17, was unchanged at 35. The number of Hispanic infant and child deaths attributed to external causes was also unchanged from 2003 to 2004 at 23. (Source: OASIS, 11/22/05)

Data are presented in this report by race and gender for each type of death to enable more detailed analysis. Race was divided into three groups: "White", "African-American (AA) and "Other" (which refers to children identified as Asian, Pacific Islander of Native American origin or multi-racial.)

Figure 48. Deaths to Children <1 and Percent of Population in Georgia by Race and Gender, 2004 (Based on Death Certificates)



	% of Deaths	% of Population
All AA Infants	52	32
AA Male Infants	28	16
AA Female Infants	24	16

Figure 48 shows the number of deaths to infants and percent of population by race and gender

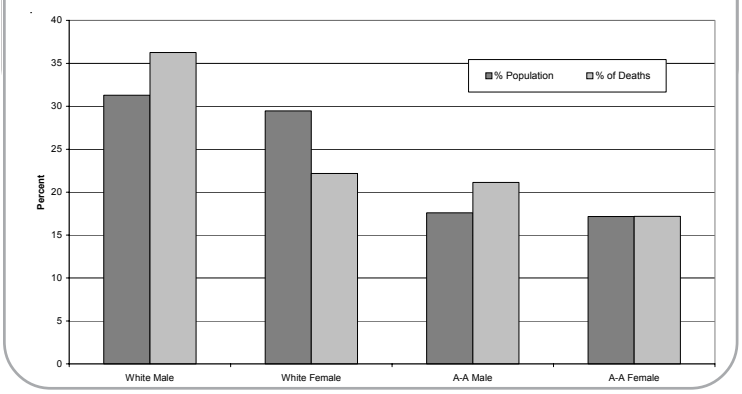
Findings:

- There are differences by cause of death, but an African-American infant is more than twice as likely as a white infant to die in the first year of life
- The death rates are higher among males than females for both races, and the sex-specific differences (rate ratios) are slightly greater among white infants

Fact:

- The racial gap in infant mortality is nearly identical for medical and external causes of death, with the overall rate of infant mortality among African-Americans about 2.2 times higher than Whites

Figure 49: Deaths to Children 1-17 and Percent of Population in Georgia by Race and Gender, 2004



	% of Deaths	% of Population
All Males 1-17	58	49
AA Male 1-17	21	18
White Males 1-17	36	31

Figure 49 shows the type number of deaths to children age 1-17 and percent of population by race and gender in 2004.

Findings:

- The racial disparities are not as pronounced for the 1 to 17 year old age group. Males are more likely to die than females, and the sex difference is greater among White youth then African-American
- The age and race differences in the adolescent death rates vary by cause of death, and the reader should refer to the cause-specific discussions of the report for additional information

Fact:

- Since 1980, child death rates have dropped dramatically. Decreases have been particularly large among those children ages one to four, with rates decreasing by more than fifty percent between 1980 and 2003 from 64 per 100,000 children ages one to four to 31 per 100,000 (preliminary estimate)

Opportunities for Prevention:

For Parents

- Seek early prenatal care and practice healthy behaviors including prenatal vitamins

For Community Leaders and Policy Makers

- Support more cultural awareness in health promotion activities in the community

For Professionals

- Educate mothers about the dangers of cigarette smoking and alcohol/drug use while pregnant. Cigarette smoking is considered the single most preventable factor for low birth weight and growth retardation

Resources:

United States Department of Health and Human Services www.os.dhs.gov

National Hispanic Prenatal Hotline: (800) 504-7081

History of Child Fatality Review

1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Require the Panel to:
  1. Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
  2. Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
  3. Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases

1996 - 1998

- The Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- Researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure, and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
  1. Identify agencies required to be represented on child fatality review teams, and establish penalties for non-participation
  2. Require that all child deaths be reported to the coroner/medical examiner in each county

1999 - 2001

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths that met established criteria within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased

2002 – 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  1. Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  2. Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  3. Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  4. Director of the Division of Mental Health added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the Office of Child Fatality Review and the National Center for Child Death Review
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members
- A Prevention Advocate was added, by policy, to all child fatality review committees. Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed. The newsletter is sent to all child fatality review members and contains useful information about the process as well as prevention
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards are presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHR, GBI and the Office of the Child Advocate
- A sub-committee of the Panel was formed to begin working on a Statewide Prevention Plan. The sub-committee also includes outside agencies working in the prevention field

Appendix A
Criteria For Child Death Reviews

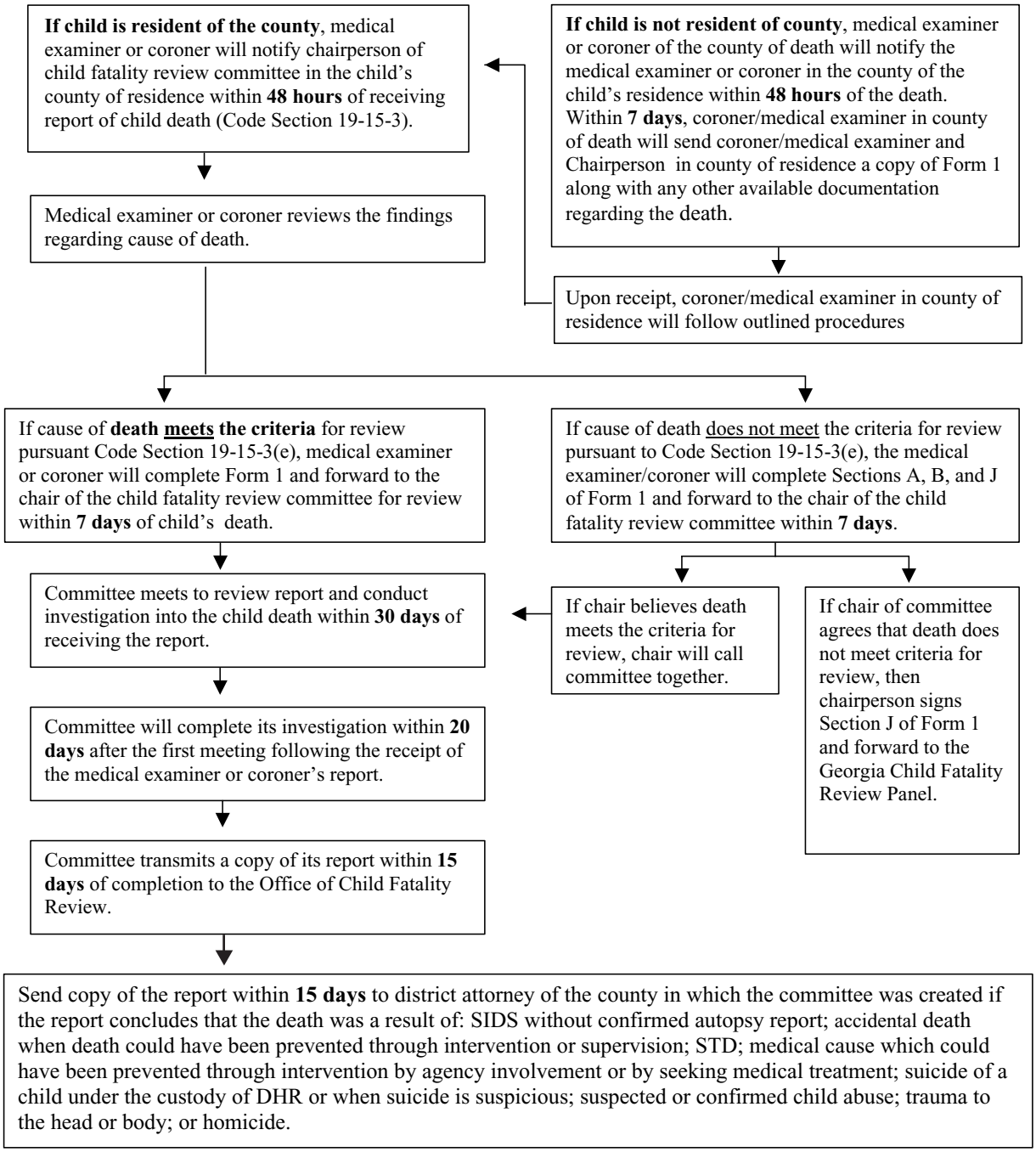
Child Fatality Review Teams are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Committees
O.C.G.A. 19-15-3 (e)

The death of a child under the age of 18 must be reviewed when the death is ***suspicious, unusual, or unexpected***. Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e., car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

Appendix B
Child Fatality Review Timeframes and Responsibilities



Appendix C.1 Total Child Fatalities Based on Death Certificate (N=1760)

Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
Infant (Age<1)								
	Drowning	2						2
	Fall	2			1			3
	Homicide	6	4	6	2			18
	Medical	234	192	276	237	15	12	966
	MVC		3	3	1	1		8
	Other Injury	1		2				3
	Other SIDS	2	1	2	1			6
	SIDS	41	25	34	25	4	1	130
	Suffocation	9	3	3	5		2	22
	Unknown	6	2	5	6	1		20
	Total	303	230	331	278	21	15	1178
Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
Age 1 to 4								
	Drowning	6	7	1			1	15
	Fall	1	1					2
	Fire	6	2	3	7			18
	Homicide	4	3	11	3	2		23
	Medical	24	18	25	14		4	85
	MVC	13	10	2	3			28
	Other Injury	6	3	1	1			11
	Poison			2				2
	Suffocation	2		1	1			4
	Unknown		1					1
	Total	62	45	46	29	2	5	189
Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
Age 5 to 14								
	Drowning	3	1	6	1		2	13
	Fall	1						1
	Fire	6		7	3			16
	Firearm	1						1
	Homicide	4	4	3	3			14
	Medical	24	22	16	30	2	1	95
	MVC	22	13	5	10	2		52
	Other Injury	3	6	2	1	1		13
	Poison	1						1
	Suffocation	5	1					6
	Suicide	6		2	1			9
	Unknown	2						2
	Total	78	47	41	49	5	3	223
Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
Age 15 to 17								
	Drowning	6		2	1			9
	Firearm	3						3
	Homicide	5	3	9	2		1	20
	Medical	12	8	13	9	1		43
	MVC	26	19	7	9		1	62
	Other Injury	8	3	3	1			15
	Poison	1						1
	Suicide	10	3	1		1		15
	Unknown	1		1				2
	Total	72	36	36	22	2	2	170

Appendix C.2 Total Reviewed Child Fatalities (N=650)

Age	Cause of Death	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
Infant (Age<1)								
	Drowning	2						2
	Fall	1						1
	Homicide	6	4	6	3			19
	Medical	7	4	11	9	2		33
	MVC		3	4	1	1		9
	Other Accident			2				2
	Poison				1			1
	SIDS	17	11	10	10	2		50
	Suffocation	10	3	4	6		2	25
	SUID	29	17	26	17	2	1	92
	Unknown	2		2	4		1	9
	Total	74	42	65	51	7	4	243
Age	Cause of Death	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
1 to 4								
	Drowning	7	7	1			3	18
	Fall	1	1					2
	Fire	8	2	6	8			24
	Homicide	4	3	10	3	2	1	23
	Medical	1	4	4	3		1	13
	MVC	17	11	2	3			33
	Other Accident		2	1				3
	Poison			2				2
	Suffocation	2		1	1			4
	Unknown			1	2			3
	Total	40	30	28	20	2	5	125
Age	Cause of Death	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
5 to 14								
	Drowning	5	2	6	1		2	16
	Fire	6		7	3			16
	Firearm	2		1				3
	Homicide	3	4	3	3			13
	Medical	3	3	3	5			14
	MVC	24	18	6	11	3		62
	Other Accident		1					1
	Poison	1						1
	Suffocation	6	1					7
	Suicide	6		3	1			10
	Unknown Intent	1						1
	Unknown	1						1
	Total	58	29	29	24	3	2	145
Age	Cause of Death	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
15 to 17								
	Drowning	7		3	1			11
	Firearm	4						4
	Homicide	4	3	9	2		1	19
	Medical	2	3	4	1			10
	MVC	33	20	10	10		1	74
	Poison	1						1
	Suicide	11	3	1		1		16
	Unknown Intent		1					1
	Unknown	1						1
	Total	63	30	27	14	1	2	137

Appendix C.3 Reviewed Child Fatalities with Abuse/Neglect Findings (N=166)

Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
Infant (<1)								
	Drowning	2						2
	Homicide	6	4	6	3			19
	Medical	1		2	2			5
	MVC			1				1
	Other Accident			2				2
	SIDS		1	2	1			4
	Suffocation	3	1	2	4		2	12
	SUID	4	3	9	4	1		21
	Unknown	2			3			5
	Total	18	9	24	17	1	2	71
Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
1 to 4								
	Drowning	4	5	1			2	12
	Fall	1						1
	Fire	4	2	1	1			8
	Homicide	4	2	9	2		1	18
	Medical			1			1	2
	MVC	5	3	1	1			10
	Other Accident		1	1				2
	Suffocation				1			1
	Total	18	13	14	5	0	4	54
Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
5 to 14								
	Drowning	2	1	1	1		1	6
	Fire	2		4				6
	Firearm	1						1
	Homicide	2	2	2	2			8
	Medical				1			1
	MVC	3	2	1	3			9
	Poison	1						1
	Suicide			1				1
	Total	11	5	9	7	0	1	33
Age	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Total
15 to 17								
	Drowning			1				1
	Homicide		1	1				2
	Medical		1	1				2
	MVC	2					1	3
	Total	2	2	3	0	0	1	8

Appendix C.4
Preventability for Reviewed Deaths with Suspected or Confirmed Abuse or Neglect (N=166)

	Preventability		
Cause of Death	Not at All	Possibly	Definitely
Drowning			21
Fall			1
Fire		2	12
Firearm			1
Homicide	3	9	35
Medical	2	8	
MVC		3	20
Other Accident			4
Poison			1
SIDS		4	
Suffocation			13
Suicide			1
SUID	1	18	2
Unknown		4	1
Total	6	48	112

Preventability for Reviewed Deaths with No Suspected or Confirmed Abuse or Neglect (N=484)

	Preventability		
Cause of Death	Not at All	Possibly	Definitely
Drowning	3	6	17
Fall		1	1
Fire		16	10
Firearm		2	4
Homicide	6	5	16
Medical	36	23	1
MVC	17	58	80
Other Accident		2	
Poison		3	1
SIDS	23	23	
Suffocation		6	17
Suicide	3	15	7
SUID	11	52	8

Appendix D
Eligible Deaths Reviewed/Eligible Deaths, Georgia, 2004

Note: A small number of child deaths were not reviewed by counties, and are not included or this map because they occurred out of state and counties were unaware of these child deaths prior to the printing of this report.

Appendix E
2004 Child Fatality Reviews, by County, by Age Groups

Appendix E presents county level data for the Child Fatality Review process in 2004. The data is presented for four age groups (infants less than one year old, children from 1 to 4 years of age, children 5 through 14, and teenagers ages 15 through 17). Four numbers are provided for each age group:

Total Deaths: The total number of deaths (all causes) for that age group. This number is generally based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia. The review team of the child's county of residence has the responsibility of reviewing deaths. However, the residence determined by the team may not match the residence reported on the death certificate. The review teams identified four deaths in 2004 that were residents of other states and were coded as Georgia residents on the death certificates. Those four deaths are not included in the child death statistics presented in this report. There were another 15 deaths that had different Georgia counties of residence on the death certificate and the CFR report, and the CFR resident county was used for the data analysis.

Reviewable Deaths: The number of SIDS, unintentional, or violence-related deaths (reviewable deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and unintentional/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH).

Reviewable Deaths Reviewed: The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "reviewable" deaths. However, there are several sources of error (or inconsistencies) in the county-level tables. The CFR team may have access to additional information regarding the death, and the team may reach a different conclusion regarding the cause of death. For example, a death certificate may be filed with "R99" (undetermined) for the cause of death. The review team may have autopsy or toxicology information that identifies a specific cause. If that is a medical cause, the review team may not complete a review. There were (at least) five deaths in 2004 that met that description, and those five were removed from the list of "reviewable" deaths.

Total Deaths Reviewed: This is the total number of child deaths in 2004 for which a Child Fatality Review Report was submitted. It includes deaths due to natural causes (other than SIDS) in addition to those deaths that were identified as eligible for review. This is based on the county of residence identified from the death certificates.

GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report
Calendar Year 2004

Office of Child Fatality Review
506 Roswell Street, Suite 230
Marietta, Georgia 30060

Phone: (770) 528-3988 | Fax: (770) 528-3989
Website: www.gacfr.dhr.georgia.gov

Mission

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication and unwavering support to child fatality review have made this report possible. These include:

- All the members who serve on each of the county child fatality review committees
- Emily Kahn, Ph.D., MPH, Nicole Alexander, MPH, Maternal and Child Health Epidemiology Section, Epidemiology Branch; Lisa Dawson, MPH and Neha Desai, MPH, Injury Prevention Section, Environmental Health and Injury Prevention Branch, Georgia Division of Public Health
- John T. Carter, Ph.D. Epidemiology Department of Emory University, Rollins School of Public Health
- Georgina Howard, Director of the Office of Vital Statistics
- All the other public/private agencies that have so willingly collaborated with this office and provided support

DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

AA
African American
Child Abuse Protocol Committee
County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.
Child Fatality Review Report
A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.
Child Fatality Review Committee
County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health.
Eligible Death
Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.
Form 1
A standardized form required for collecting data on all child fatalities by corners or medical examiners.
Georgia Child Fatality Review Panel
An appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.
Injury
Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.
Intentional
Refers to the act that resulted in death being one that was deliberate, willful, or planned.
Medical Cause
Refers to death resulting from a natural cause other than SIDS.
Natural Cause
Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.
"Other" Race
Refers to those of Asian, Pacific Islander, or Native American origin.
"Other" as Category of Death
Includes deaths from poisoning and falls (unless otherwise indicated).
Perpetrator
Person(s) who committed an act that resulted in the death of a child.
Preventable Death
One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.
Reviewed Death
Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.
Risk Factor
Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.
Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause.
Sudden Unexplained Infant Death (SUID) is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors that could have contributed to the infant's death.
Trend
Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.
Unintentional Death
Refers to the act that resulted in death being one that was not deliberate, willful, or planned.

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Schley	1	1			2		1			1	1	1			1	1	1			1
Screven	3		1		4	1				1	1				1	1				1
Seminole	1	1	3	1	6		1	3		4		1	3		4			3		4
Spalding	9	4	3		16	2	3	2		7	2	3	2		7	3	3	2		8
Stephens	2			1	3															
Stewart	1				1															
Sumter	10				10	1				1	1				1	1				1
Talbot	1				1															
Taliaferro																				
Tattnall	3				3															
Taylor	1				1															
Telfair	3		1		4	1		1		2	1		1		2	2		1		3
Terrell	2		1		3															
Thomas	6	3	2	1	12	1				1	1				1	2	1			3
Tift	3	1			4															
Toombs	6			1	7				1	1				1	1	1			1	2
Towns	1		2		3			1		1			1		1			1		1
Treutlen	1				1															
Troup	8	2	2	1	13	3	1	1	1	6	2	1	1	1	5	4	2	1	1	8
Turner	1	1	1		3		1	1		2		1	1		2		1	1		2
Twiggs	2		1		3															
Union			1		1															
Upson	3		1		4	1				1	1				1	1				1
Walker	4	2	4		10	3	1	3		7	3	1	3		7	3	1	3		7
Walton	12	3	3	2	20		2	2	1	5		2	2	1	5		2	2	1	5
Ware	5	1	2		8	1		1		2		1	1		2	2	1	1		4
Warren																				
Washington	2				2															
Wayne	2			2	4				1	1				1	1				1	1
Webster	1				1															
Wheeler	2		1	1	4															
White	2		1	1	4	1		1	1	3	1		1	1	3	1		1	1	3
Whitfield	7	2	2	1	12	1	1	1		3		1	1		2		1	1		3
Wilcox	1			1	2															
Wilkes	1				1															
Wilkinson	2				2	1				1	1				1	1				1
Worth	2		2	3	7	1		1	1	3	1		1	1	3	1		1	2	4
Totals	1,157	185	217	164	1,723	205	102	123	123	553	200	102	123	123	548	237	123	141	133	634

GEORGIA CHILD FATALITY REVIEW PANEL

MEMBERS

Chairperson
Edward D. Lukemire
Superior Court Judge, Houston Judicial Circuit

DeAlvah Simms
Child Advocate for the Protection of Children[3]

Mary Burns, M.D.
Board Chair, Dept. of Human Resources[3]

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Stuart Brown, M.D.
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Child Abuse Prevention Advocate

J. David Miller
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Georgia Bureau of Investigation[3]

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Kevin Tanner
Chief Deputy
Dawson County Sheriff's Office

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Investigation Team Director

Carri Cottengim
Program Manager

Arleymah Raheem
Program Manager

The Georgia Child Fatality Review Panel is an appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

[1]Appointed by the Lieutenant Governor
[2]Appointed by the speaker of the House of Representatives
[3]Ex-Officio

Georgia Child Fatality Review Panel

Dear Governor and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, I am pleased to present the 2004 Annual Report. This report is the product of the tireless efforts made by hundreds of volunteers across this state, volunteers in each local child fatality review committee. The work they do in gathering, reviewing and reporting information on child fatalities is invaluable in the fight to protect Georgia's children. The information they provided in 2004 reveals "mixed" results in this battle. For example, the number of deaths resulting from confirmed and suspected abuse and/or neglect increased in 2004, and the number of SIDS deaths was twenty-one percent greater than in 2003. However, there was an appreciable decrease in child deaths attributed to motor vehicle accidents, and deaths from homicides and suicides showed no increase from 2003. A careful reading of the entire report offers some encouragement, but also compels the conclusion that there is still much to be done.

For its part in this struggle, the Panel was very active in 2004, and met with success on several fronts, including the following:

* Achieved a ninety-nine percent compliance rate for county committees reviewing child deaths eligible for review. This is the highest compliance rate in Georgia Child Fatality Review history (95% in 2003, 88% in 2002 and 75% in 2001);

* Increased the number of partnerships to provide training and assistance with local prevention efforts. Partnerships included the Georgia SIDS Project, Georgia Traffic Injury Prevention Institute and Public Health;

* Distributed over 1,000 gun locks to county committees for local distribution;

* Initiated annual recognition of county efforts through the "Coroner of the Year," and "County Committee of the Year" awards;

* Created five additional Child Fatality Investigation Teams;

* Realized the appointment of our Executive Director to service on the National Child Death Review Advisory Board;

* Hosted the Southeast Coalition of Child Death Review Program's Annual Meeting;

* Co-sponsored an annual conference with DFCS, Office of Child Advocate and GBI on serious injury and child fatality.

As we review what has been accomplished in the fight to reduce child fatalities in Georgia, and as we make plans for our continued prosecution of this effort, we want to again thank you for your role in all of this. Your leadership, financial backing and counsel enable this Panel, local review committees and numerous participating agencies to carry on. And we will do just that; certainly the prize is well worth the effort.

Edward D. Lukemire,
Chairperson,
Georgia Child Fatality
Review Panel

County	All Deaths <1	All Deaths 1-4	All Deaths 5-14	All Deaths 15-17	All Deaths Total	Reviewable Deaths <1	Reviewable Deaths 1-4	Reviewable Deaths 5-14	Reviewable Deaths 15-17	Reviewable Deaths Total	Total Deaths Reviewed <1	Total Deaths Reviewed 1-4	Total Deaths Reviewed 5-14	Total Deaths Reviewed 15-17	Total Deaths Reviewed Total
Jeff Davis	2	1	1		4		1					1			1
Jefferson	4			1	5				1	1				1	1
Jenkins	1	1			2			1		1		1			1
Johnson	1				1						1				1
Jones	1		1	2	4	1			2	3				2	3
Lamar	3	1	1		5	1	1			2	1	1			2
Lanier				2	2				1	1				1	1
Laurens	5	2		1	8	2			1	3	2			1	3
Lee	2				2										
Liberty	15	2			17	3	2			5	3	2			5
Lincoln															
Long	1				1										
Lowndes	25	3		3	31	5	1		3	9	5	3		3	11
Lumpkin	2		1		3	1				1	1				2
Macon	2				2	2				2	1				2
Madison	2			1	3	1			1	2	1	1			2
Marion	2				2						2				2
McDuffie	8		1		9	1				1	1		1		2
McIntosh	2	1		1	4		1			1		1			1
Meriwether	1	3			4		2			2		2			2
Miller		1			1										
Mitchell	3	1			4	1				1	1				1
Monroe	1	1			2		1			1	1	1			2
Montgomery	1			1	2										
Morgan	1			1	2				1	1	1	1			2
Murray	6	2	1	2	11	2	2		2	4	1	3	1		5
Muscogee	42	4	5	2	53	5	3	3	1	12	4	3	3	1	11
Newton	4	4	4	2	14	1	2	1	1	5	1	2	1	1	5
Oconee	1				1	1				1	1				1
Oglethorpe	4				4	1				1	1				1
Paulding	14	1	4	1	20	2		1	1	4	1	1	4		6
Peach	3				3	1				1					
Pickens	4		1		5	2			1	3	1		1		2
Pierce	2		2	3	7	1		2	3	6		1	3	2	6
Pike	2			1	3	2			1	3	2		1	1	4
Polk	6	3	1	1	11		3		1	4		3	1		4
Pulaski			1		1				1	1			1		1
Putnam	4				4										
Quitman	3				3										
Rabun	1			1	2				1	1			1		1
Randolph	1				1										
Richmond	33	7	5	5	50	7	5	1	4	17	9	5	1	4	19

County	All Deaths <1	1-4	5-14	15-17	Total	Reviewable Deaths <1	1-4	5-14	15-17	Total	Reviewed Deaths <1	1-4	5-14	15-17	Total
Cook	2	1	1		4	1	1			2	1	1			2
Coweta	14	1	2	3	20	4	1	2	3	10	4	1	2	3	10
Crawford															
Crisp	2	2	1		5	2	2	1		5	2	2	1		5
Dade	1				1									1	1
Dawson	1			1	2				1	1				1	1
Decatur	2		1		3										
DeKalb	100	8	19	11	138	15	5	7	5	32	18	5	9	8	40
Dodge			2	1	3			1	1	2			1	1	2
Dooly	3		1	1	5			1	1	2			1	1	2
Dougherty	23	2	3	1	29	5	1	1	3	10	5	1	1	3	10
Douglas	17	2	1	4	24	6		1	3	10	6		1	3	10
Early	3		1		4			1		1			1		1
Echols	4		1		1			1		1			1		1
Effingham	6		1		7	1				1			1		1
Elbert	3		2		5			1		1			1		1
Emanuel	4				4	1				1					
Evans	4			1	5	1				1				1	1
Fannin															
Fayette	4	3		4	11										
Floyd	19	1	6	4	30	3									
Forsyth	13	2	3	1	19	3									
Franklin	4		3		7	1									
Fulton	92	15	19	14	140	18	8	13	13	52	23	11	13	14	61
Gilmer	12	2	1	1	16	1	2	1	1	5	1	2	1	1	5
Glascock															
Glynn	10	2	1	2	15	2	2	1	1	6	2	2	1	1	6
Gordon	10	1			11	4				4	4	1			5
Grady	5		1		6	1				1	2				2
Greene	2			1	3	1			1	2	1			1	2
Gwinnett	90	13	15	10	128	14	5	10	8	37	21	6	13	8	48
Habersham	3	1	2		6	1	1	1		3	1	1	1		3
Hall	18	8	2	2	30		6	1	2	9		6	1	2	9
Hancock	4				4							2			2
Haralson	2		1		3	2									
Harris	3		1		4			1		1			1		1
Hart	3		1	1	5	1			1	2			1	1	3
Heard	1				1										
Henry	18	3	4	4	29										
Houston	23	5	2	4	34	4	1		4	9	5	3	2	4	14
Irwin	1				1										
Jackson	6	1		2	9	1	1		2	4	1	1		2	4

TABLE OF CONTENTS

	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
County	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Appling	4	1			5											1				1
Atkinson	2		2	1	5	1		1		2	1		1		2	1		1		2
Bacon	1				1															
Baker																				
Baldwin	4		1		5			1		1			1		1			1		1
Banks	1			1	2				1	1				1	1				1	1
Barrow	6		1	1	8	1				1	1				1	1				1
Bartow	9	2	3		14		1	2		3		1	2		3		1	2		3
Ben Hill	4	1	1		6	2		1		3	2		1		3	2	1	1		4
Berrien	2	1	3		6		1	3		4		1	3		4		1	3		4
Bibb	33	3	1	5	42	7	2		4	13	7	2		4	13	7	2		4	13
Bleckley	2				2															
Brantley	2			1	3	1			1	2	1			1	2	1			1	2
Brooks	1			3	4				3	3				3	3				3	3
Bryan	1		1	1	3	1			1	2	1			1	2	1			1	2
Bulloch	10	2	2	1	15		1	1	1	3		1	1	1	3		1	1	1	3
Burke	3				3															
Butts	2		1		3			1		1			1		1			1		1
Calhoun		1			1												1			1
Camden	4	2	4	1	11	1	1	3	1	6	1	1	3	1	6	1	1	3	1	6
Candler	2			1	3				1	1				1	1				1	1
Carroll	8	2	3	1	14	2	2	3	1	8	2	2	3	1	8	2	2	3	1	8
Catoosa	6	1	2	1	10	4	1		1	6	4	1		1	6	4	1		1	6
Charlton		1			1		1			1		1			1		1			1
Chatham	37	5	2	4	48	2	2	1	3	8	2	2	1	3	8	5	3	3	3	14
Chattahoochee	1	1			2	1	1			2		1			1		1			1
Chattooga	2		3	2	7			2	2	4			2	2	4			3	2	5
Cherokee	15	3	4	3	25	8	2	3		13	8	2	3		13	8	2	3		13
Clarke	13	2	1		16	3	1			4	3	1			4	3	1			4
Clay																				
Clayton	50	5	6	7	68	7	2	4	6	19	7	2	4	6	19	10	4	4	6	24
Clinch		2	1		3		2	1		3		2	1		3		2	1		3
Cobb	69	14	13	9	105	6	6	7	3	22	5	6	7	3	21	7	7	8	6	28
Coffee	2	3	1		6		1			1		1			1		1			1
Colquitt	7	1		1	9	1	1		1	3	1	1		1	3	1	1		1	3

	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
County	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Cook	2	1	1		4	1	1			2	1	1			2	1	1			2
Coweta	14	1	2	3	20	4	1	2	3	10	4	1	2	3	10	4	1	2	3	10
Crawford																				
Crisp	2	2	1		5	2	2	1		5	2	2	1		5	2	2	1		5
Dade	1				1														1	1
Dawson	1			1	2				1	1				1	1				1	1
Decatur	2		1		3															
DeKalb	100	8	19	11	138	15	5	7	5	32	15	5	7	5	32	18	5	9	8	40
Dodge			2	1	3			1	1	2			1	1	2			1	1	2
Dooly	3		1	1	5			1	1	2			1	1	2			1	1	2
Dougherty	23	2	3	1	29	5	1	1	1	8	5	1	1	1	8	5	1	1	1	8
Douglas	17	2	1	4	24	6		1	3	10	6		1	3	10	6		1	3	10
Early	3		1		4			1		1			1		1			1		1
Echols			1		1			1		1			1		1			1		1
Effingham	6		1		7	1				1	1				1	1		1		2
Elbert	3		2		5			1		1			1		1			1		1
Emanuel	4				4	1				1	1				1	1				1
Evans	4			1	5	1			1	2	1			1	2	1			1	2
Fannin																				
Fayette	4	3		4	11				3	3				3	3				4	4
Floyd	19	1	6	4	30	3		5	3	11	3		5	3	11	4		7	3	14
Forsyth	13	2	3	1	19	3		2		5	3		2		5	3	1	2		6
Franklin	4		3		7	1		2		3	1		2		3	1		2		3
Fulton	92	15	19	14	140	18	8	13	13	52	18	8	13	13	52	23	11	13	14	61
Gilmer	12	2	1	1	16	1	2	1	1	5	1	2	1	1	5	1	2	1	1	5
Glascock																				
Glynn	10	2	1	2	15	2	2	1	1	6	2	2	1	1	6	2	2	1	1	6
Gordon	10	1			11	4				4	4				4	4	1			5
Grady	5		1		6	1				1	1				1	2				2
Greene	2			1	3	1			1	2	1			1	2	1			1	2
Gwinnett	90	13	15	10	128	14	5	10	8	37	14	5	10	8	37	21	6	13	8	48
Habersham	3	1	2		6	1	1	1		3	1	1	1		3	1	1	1		3
Hall	18	8	2	2	30		6	1	2	9		6	1	2	9		6	1	2	9
Hancock	4				4												2			2
Haralson	2		1		3	2				2	2				2	2				2
Harris	3		1		4			1		1			1		1			1		1
Hart	3		1	1	5	1			1	2	1			1	2	1		1	1	3
Heard	1				1															
Henry	18	3	4	4	29	5	2	3	3	13	5	2	3	3	13	5	3	3	4	15
Houston	23	5	2	4	34	4	1		4	9	4	1		4	9	5	3	2	4	14
Irwin	1				1															
Jackson	6	1		2	9	1	1		2	4	1	1		2	4	1	1		2	4

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Jeff Davis	2	1	1		4		1			1		1			1		1			1
Jefferson	4			1	5				1	1				1	1				1	1
Jenkins	1	1			2		1			1		1			1		1			1
Johnson	1				1											1				1
Jones	1		1	2	4	1			2	3	1			2	3	1			2	3
Lamar	3	1	1		5	1	1			2	1	1			2	1	1			2
Lanier				2	2				1	1				1	1				1	1
Laurens	5	2		1	8	2			1	3	2			1	3	2			1	3
Lee	2				2															
Liberty	15	2			17	3	2			5	3	2			5	3	2			5
Lincoln																				
Long	1				1															
Lowndes	25	3		3	31	5	1		3	9	5	1		3	9	5	3		3	11
Lumpkin	2		1		3	1		1		2	1		1		2	1		1		2
Macon	2				2	2				2	2				2	2				2
Madison	2			1	3	1			1	2	1			1	2	1			1	2
Marion	2				2											2				2
McDuffie	8		1		9	1				1	1				1	1		1		2
McIntosh	2	1		1	4		1			1		1			1		1			1
Meriwether	1	3			4		2			2		2			2		2			2
Miller		1			1															
Mitchell	3	1			4	1				1	1				1	1				1
Monroe	1	1			2		1			1		1			1		1			1
Montgomery	1			1	2															
Morgan	1			1	2				1	1				1	1				1	1
Murray	6	2	1	2	11	2	2		2	6	2	2		2	6	2	2		2	6
Muscogee	42	4	5	2	53	5	3	3	1	12	4	3	3	1	11	4	3	3	1	11
Newton	4	4	4	2	14	1	2	1	1	5	1	2	1	1	5	1	2	1	1	5
Oconee	1				1	1				1	1				1	1				1
Oglethorpe	4				4	1				1	1				1	1				1
Paulding	14	1	4	1	20	2		1	1	4	2		1	1	4	2		1	1	4
Peach	3				3	1				1										
Pickens	4		1		5	2		1		3	1		1		2	2		1		3
Pierce	2		2	3	7	1		2	3	6	1		2	3	6	1		2	3	6
Pike	2			1	3	2			1	3	2			1	3	2			1	3
Polk	6	3	1	1	11		3		1	4		3		1	4		3		1	4
Pulaski			1		1			1		1			1		1			1		1
Putnam	4				4															
Quitman	3				3															
Rabun	1			1	2				1	1				1	1				1	1
Randolph	1				1															
Richmond	33	7	5	5	50	7	5	1	4	17	7	5	1	4	17	9	5	1	4	19

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Schley	1	1			2		1			1		1			1		1			1
Screven	3		1		4	1				1	1				1	1				1
Seminole	1	1	3	1	6		1	3		4		1	3		4		1	3		4
Spalding	9	4	3		16	2	3	2		7	2	3	2		7	3	3	2		8
Stephens	2			1	3															
Stewart	1				1															
Sumter	10				10	1				1	1				1	1				1
Talbot	1				1															
Taliaferro																				
Tattnall	3				3															
Taylor	1				1															
Telfair	3		1		4	1		1		2	1		1		2	1		1		2
Terrell	2		1		3															
Thomas	6	3	2	1	12			2	1	3			2	1	3			2	1	3
Tift	3	1			4															
Toombs	6			1	7				1	1				1	1				1	1
Towns	1		2		3			1		1			1		1			1		1
Treutlen	1				1															
Troup	8	2	2	1	13	3	1	1	1	6	3	1	1	1	6	4	2	1	1	8
Turner	1	1	1		3		1	1		2		1	1		2		1	1		2
Twiggs	2		1		3															
Union			1		1													1		1
Upson	3		1		4	1				1	1				1	2		1		3
Walker	4	2	4		10	3	1	3		7	3	1	3		7	3	1	3		7
Walton	12	3	3	2	20		2	2	1	5		2	2	1	5		2	2	1	5
Ware	5	1	2		8	1		1		2	1		1		2	2	1	1		4
Warren																				
Washington	2				2															
Wayne	2			2	4				1	1				1	1				1	1
Webster	1				1															
Wheeler	2		1	1	4			1	1	2			1	1	2			1	1	2
White	2		1	1	4	1		1	1	3	1		1	1	3	1		1	1	3
Whitfield	7	2	2	1	12	1	1	1		3	1	1	1		3	1	1	1		3
Wilcox	1			1	2				1	1				1	1				1	1
Wilkes	1				1															
Wilkinson	2				2															
Worth	2		2	3	7	1		1	2	4	1		1	2	4	1		1	2	4
Totals	1,157	185	217	164	1,723	205	102	123	123	553	200	102	123	123	548	237	123	141	133	634

DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

AA
African American

Child Abuse Protocol Committee
County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

Child Fatality Review Report
A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.

Child Fatality Review Committee
County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health.

Eligible Death
Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

Form 1
A standardized form required for collecting data on all child fatalities by corners or medical examiners.

Georgia Child Fatality Review Panel
An appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

Injury
Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

Intentional
Refers to the act that resulted in death being one that was deliberate, willful, or planned.

Medical Cause
Refers to death resulting from a natural cause other than SIDS.

Natural Cause
Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

"Other" Race
Refers to those of Asian, Pacific Islander, or Native American origin.

"Other" as Category of Death
Includes deaths from poisoning and falls (unless otherwise indicated).

Perpetrator
Person(s) who committed an act that resulted in the death of a child.

Preventable Death
One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.

Reviewed Death
Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.

Risk Factor
Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause.

Sudden Unexplained Infant Death (SUID) is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors that could have contributed to the infant's death.

Trend
Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.

Unintentional Death
Refers to the act that resulted in death being one that was not deliberate, willful, or planned.